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DRAFT

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

Jan. 22, 2001 4:30 PM

AGENDA

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I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 12/18 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *SF Department of Public Health* HIV Health Services Presentation	**4:55 PM**
	• *Responding to Racial & Ethnic Disparities in HIV Care (Part 1)* Presentation by Dr. Stephen F. Morin, AIDS Policy Research Center, UCSF	**5:10 PM**
	• *Membership Committee* -Council Nominees – **VOTE**	**5:45 PM**
Break		**6:00 PM**
	• *Steering Committee* -Notice of Bylaws Revision Vote, Clarification of Policy on Reimbursements	**6:20 PM**
	• *PWA Caucus* -Tenderloin Community Forum	**6:35 PM**
	• *Implementation & Evaluation Committee* -Resolution of Grievance on Hold Harmless	**6:50 PM**
	• *Housing Committee*	**7:15 PM**
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

Upcoming schedule of dates/meetings:

Day	Date	Type of meeting	Location	Time
Mon	1/29	Bylaws Revision Ad-hoc Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Wed	1/31	Tenderloin Community Forum	201 Turk St.	6:30 – 8:00 PM
Mon	2/5	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	2/7	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	2/7	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	2/12	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Thurs	2/15	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	2/19	President's Day Holiday		
Mon	2/26	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	3/5	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM

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Membership Committee December Report

Meeting Date: December 14, 2000

Meeting Place: 25 Van Ness Ave., Room 330-A

Meeting Time: 5:30 to 7:00 PM

Members Present: Laura Carcagno Guzman, Ken Pearce, Greg Neumark, Janis Takamoto, and Bob Teague

Others Present: Steven Feeback, minutes; Donald Frasier, nominee; Kenny Landes, nominee; and Karen Wupio, nominee.

Next Meeting: Thursday, January 18, 2000, 25 Van Ness, Room 330A, 5:30-7:00 PM
Meetings will generally be held on the 3rd Thursday of each month.

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Introductions

Discussion with Nominees

Ken Pearce asked Karen Wupio to go first and present some background information. She has worked for the past five years with the Marin County AIDS Program. She spent several of those years in a primary care clinic, then moved up the line to her current position as Chief of AIDS Surveillance for the County. She wants Marin to have a voice on the Council and its representative Kelly Wallace has not been able to attend at the required level of late. She realizes how much impact the Council has on the services received by clients in the County. There needs to be at least one person working to take the information back to the Marin AIDS Commission, the sub-contractors there, and out into the community. The County's AIDS Commission has 15-17 members and has been active since the early 80s. It is more of an advisory body to the County, rather than a priority setting body. They have just revised their Bylaws and set a mandate of having 51% of membership from those who are consumers of services. They are now actively working toward that goal, but she feels it has historically been harder for them to motivate and recruit PWAs who want to make their voices heard.

KP asked Kenny Landes to go next. He is applying as an unaffiliated consumer. He was invited to start attending the Council as part of the PWA Caucus by suggestion of Cecilia Chung who he has known for about five years. He feels he has had the virus for a relatively short time, two years. Since then he has had contact with several service providers: treatment for addiction, primary health care, mental health, dental care, and advocacy services among others. He is going back to school on his road to going back to work. He feels he has a valuable point of view to contribute to the Council and wants to work with the PWA Caucus. He has started working with the Caucus on a project to compile a comprehensive list of services that are available regardless of funding source. He views his involvement in the Council as a way of giving back in return for some of the services he has received. He has lived in San Francisco for eight years. *LCG* asked about his ability to participate and speak up in the context of a rather large group of people. Kenny sited his work as a Group Service Representative on a Council that serves people in recovery. Its agenda is mainly business, but in the context of that large group he has no trouble speaking out. Time commitments were discussed.

KP asked Donald Frasier to go next. He began by saying that as an African American gay man living with HIV he feels strongly that voice should be heard. One of his interests is to represent that voice in community service and his job as well as through the Council if he should be appointed. Through his work with Walden House, he first attended some Council meetings with a member at that time, Lisa O'Connor. His understanding is that the work of the Council is very important for allocating funds and

ensuring the delivery of services. He started as a counselor at Walden House, then worked in Resource Development, and now is a Contracts and Compliance Manager. His community and social service work has been of benefit to people in Tucson, Phoenix and San Diego before coming to San Francisco about 15 months ago. His background includes some direct services at the Tucson AIDS Project as well as assisting with the development of targeted programs for people of color. He was asked about his ability to maintain the required levels of participation in Council and committee work. He was also asked if he has the capacity to be a strong and outspoken advocate. He feels that he has a clear voice and that he does well in stating his positions even in large groups. He has attended several meetings of the full Council.

Analysis of Current Membership and Areas of Representation

KP said that the Council had seven openings, with further resignations over the next few months most likely leading to additional open seats. He reminded everyone about the report from last month made by Laura Thomas that the percentage of the Council's seats occupied by people who are openly HIV-positive is below the desired level of 50%. The top priority for recruitment is consumers of services. All three of the nominees attending this meeting were considered fine candidates. There is certainly a mandated seat for Marin County, but some question about who will be that representative. This will get worked out during the next few months. There are two nominees who are HIV+, but only one of them nonaffiliated. We need to talk with Laura Thomas about doing a new survey of membership about their work and board affiliations in order to have a clear idea of the current status in order to clarify who is unaffiliated. It is estimated that about nine or ten out of the current membership are unaffiliated, but we need to get definite numbers. We also need members who have experience in substance use/abuse services. Even though all three nominees would be recommended for approval at the full Council and submission to the Mayor, it was decided to wait until the January meeting to send a larger number to the Mayor at one time. All three were approved by unanimous vote of the Membership Committee and will be put before the Council at its meeting January 22. Members will continue to be on the lookout for prospective new members. Ken Pearce, Laura Guzman and Janis Takamoto have prospects. New applications were briefly reviewed and names were put forward. Not all of them have submitted their application forms as yet.

Orientation and Training

Bob Teague acknowledged that the proposal put forward at the 11/27/00 Council meeting is a framework for what is needed in terms of training and that the Meeting's Minutes serve the purpose of actually requesting that the AETC conduct orientation and training for the Council. He passed around a copy of HRSA's orientation and resource guide for Ryan White Councils across the country. He would like to do trainings for the Council on an on-going basis. He will now write a letter to the Co-chairs of the Council in order to formalize this arrangement. It is part of the Technical Assistance that the AETC is funded to do. The Membership Committee wants to continue being active in planning for orientation of new members and periodic training for all members. The AETC will prepare outlines for a series of trainings, such as a session focused on group process, bylaws and procedures. The first one got scheduled after the meeting—for Saturday January 20, 2001 at 9:00 AM in room 330, 25 Van Ness Ave.

Bylaws Changes due to Language in Reauthorized CARE Act

LCG reported that Laura Thomas has drawn up some suggestions for the sections of Council Bylaws that may need revision. This will get discussed at the next meeting of the Membership Committee and it is planned that the results will be properly noticed to the public at the Council Meeting on January 22 for a vote at the subsequent meeting.

Attendance and Compliance Issues

Several Council members have been violating the minimum mandatory requirements for the past quarter and in some cases the past few quarters. They will get phone calls from someone on the Membership Committee.

January Report
Housing Committee

To:	Members, HIV Health Services Planning Council
Meeting Date:	January 3, 2001
Meeting Place:	25 Van Ness Ave., Room 330-A
Members Present:	Hazel Betsey, John Conley, Catherine Geanuracos, Fernando Gomez-Benitez, Brad Hume, Ali Riker (Chair), and Mary Jane Wood.
Others Present:	Carol Carbone, TARC; Steven Feeback, minutes; Susan Haikalis, SFAF; Daisy Leyva, DPH (Housing); Ramon Matos, SFAF; and Laura Thomas, DPH-HHS.
Next Meeting:	Wednesday, Feb. 7, 2001, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Update from Reinvisioning AIDS Emergency Housing

Daisy Leyva reported that contractors had been determined. Page Street Guest House, an agency that runs another Residential Care Facility, was selected for the new RCF Program. Baker Places, in association with LSS, TARC and the John Stewart Company, was selected for the two renovated facilities to be operated as transitional housing. The master leases are being developed. That will be followed by the contract negotiations. She thinks that all three will be operating by April, 2001, with the RCF possibly coming online sooner than the other two buildings. The emergency voucher program will still run as it currently does through June 30th, and the revised program with a 20-unit block of rooms will start July 1, 2001. There had been two bidders for the RCF and one for the other two buildings. This was a higher rate than in the past.

Outreach Plan

Brad Hume reminded the committee about the Tenderloin Community Forum scheduled for January 31st and requested that some information be put forward about the changes coming to emergency housing. Several members of the committee volunteered to attend the forum, with Marc Trotz hopefully representing DPH-Housing Services and Ali Riker or Brad Hume speaking about the mission of the Housing Committee.

I&E Committee Recommendation on "Hold Harmless"

Hazel Betsey gave a capsule of what took place at the 12/18/00 Council meeting with regard to the presentation of a grievance. That issue will have to be dealt with by the I&E Committee at their next meeting. The grievance involves the conflict-of-interest issue. No vote was taken with regard to a recommendation to hold any services harmless. This will have the effect of preventing HIV Health Services staff from starting the negotiation process with any contractors and may slow some processes. Laura Thomas reported that there still had been no notification about the grant award or the amount of funds for the fiscal year starting March 2001. Therefore, reductions are still speculative, but we are anticipating some cuts. She will send an email if she hears anything before the 1/22/01 Council meeting. Housing Committee members were encouraged to attend the next I&E Comm.

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Co-Chair Elections

Ali Riker said that she wanted to hand over leadership. She talked about the upcoming work of the committee in order to prepare members for reflection on the time commitments. She invited volunteers and/or nominees. Ali will continue working with the HOPWA Loan Committee and will continue serving as a member of this committee. Brad Hume volunteered to serve as co-chair and Hazel Betsey said she would continue doing it unless someone else wanted to volunteer. The two of them were approved by acclamation.

February Agenda

AR suggested another look at the committee's goals and objectives. She also said that she would like further discussion about the committee's role in outreach about the changes in emergency housing and the use of vouchers. *Fernando Gomez-Benitez* encouraged DPH-Housing to project a media plan in addition to working with the providers. *Daisy Leyva* responded that things will be more together by March, and the usual procedure is to develop an information packet to be sent to access points. She said they would consider providing some information directly to potential client populations, perhaps via a media effort. *Mary Jane Wood* suggested that the committee examine any potential strategies for responding to threats of cuts to programs in the Housing category. The SF AIDS Foundation was able to successfully advocate for the restoration of funding cuts through the use of General Fund dollars. This type of campaign might prove useful in the future as well. Under level funding the subsidies get reduced anyway due to rising rents and "fair market rates." The case must continually be made for how important housing is. Increases are needed in the housing category. Stable housing is a necessity for health. We need a coordinated advocacy campaign in order to obtain housing services for people with HIV and AIDS. The housing funds for Redevelopment and for HOPWA should be included in an overall analysis of the current situation. *MJW* also asked about the status of HOPWA funding in capital projects. *FGB* also wanted the committee to further address the critical situation with regard to SRO housing conditions.

HIV Health Services Planning Council
Implementation and Evaluation Committee

January Report

Meeting Date/Time: Monday, January 8, 2001, 5:00pm – 7:00pm

Members Present: Gene Gowdey, I & E C0-Chair, Jeff Byers, Raymond Combs, John Conley, Catherine Geanuracos, Gene London, Jim Mitulski, Susan Shea, Mary Jane Wood, Gary Harrell, Gregory Edwards, Laura Carcagno Guzman, Allisa Riker, and Hazel Betsey.

Others Present: Marshia Herring, A.O., J. Cecere, A.O., Elyse Graham Immune Project Enhancement, Carla Wilson, Quan Yin Healing Arts Center, Amy Cunninghis, SF AIDS Foundation, Pam Sims, SF Redevelopment Agency, Elizabeth Colomello, SF Redevelopment Agency, Chris Callandrillo, CCASF, George Simmons, CCASF, Jamie Lavender, Glide Health Services, Tom Calvanese, TARC, Russ Zeller, HHS, Jim Rilley, AIDS Health Project, Marcy Frazer, Continuum, Bill Musick, Charlotte Bobek, UCSF Positive Health Program, Celinda Cantu, HIV Health Services, Naomi Prochovnick, Lyon Martin Women's Health Services, Jennifer McGaugh, Shanti, Phillip Watson, Shanti, Anne Quaintance, SF Food Bank, Kevin Johnson, Black Coalition on AIDS, Rachel Matillano, Asian Pacific Island Wellness Center, Laura Thomas, DPH/AIDS Office, Michelle Long Dixon, SFDPH/A.O., Robert Owens, Minutes-Positive Resource Center.

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Call to Order
GG gave a call to order.

Introduction
Participants present introduced themselves.

Review and Approval of Agenda
GG reviewed the agenda and asked for Marcy Fraser to give a summary of the Formal Grievance: Planning Council Conflict of Interest. Vote on finalizing service categories to be "held Harmless" for the next fiscal year of CARE funding.

Review of Meeting Objective
Was there a conflict of interest during the vote whether or not to "hold harmless" a service category, if council members are at all financed by that category, should they have disqualified themselves from the vote? And was voting by 2/3 majority or a simple 50%+1 majority?

Discussion on Conflict of Interest in vote on to be held harmless

Marcy Fraser asked how is conflict on interest managed during voting and said that some issues were not given full weight. Mary Jane Wood said that conflict of interest was ambigous and she lacked the understanding of how to deal with conflict of interest and how to facilitate it. She stated that if you are not going to vote then you should not participate in the discussion. Members who participate and then do not vote are affecting others with their opinions even when they have a conflict of interest. Susan Shea said that she can understand speaking to the issue even if you are not voting; example would be that public members can speak to the issue and they do not have a vote; it seems odd that members are not afford the same rights. Mary Jane Wood said that this was the standard presented to her from the City Attorney and in separate settings has allowed questions from non-voting participants. Raymond Combs asked is there any mention of how to handle conflict of interest in the by-laws. Jeff Byers said that the public is not allowed to participate in all meetings, and would like to use experts from other meetings and have the city council members set guidelines for conflict of interest. Marcy Fraser spoke to discussion thus far stating that there should be no participation if agency is receiving funding from vote action, council members need to reveal conflict of interest before speaking on issue, by-laws needs to be evaluated for credibility and influence of conflict of interest, and should council members vote if not fully present during discussion. Gene Gowdey asked what specifically happened that brought forth this grievance. Was there conflict of interest and was it excused, there was a 2/3 vote, and do we need more education and experts to aide in discussion of conflict of interest. Jeff Byers stated that the vote was 2/3 and that there was only one vote that had a conflict of interest, all members agreed. JB said that the perception and attitude to conflict of interest resulted in this grievance; then he asked should we rescind the vote? Susan Shea said that the issues are that we need more education about conflict of interest before re-visiting the issues and vote; if the is a perception of conflict of interest then the vote needs to be rescinded, and there is a need to re-visit the hold-harmless vote. Gene Gowdey asked for more discussion. Tom Calvanese said not to rescind. Gene London said that we need training on conflict of interest and he would favor rescinding the vote. Mary Jane Wood stated that the process didn't work and there is a nay-say with each motion. Susan Shea said to table the discussion pending more training and information on conflict of interest and grant information.

Susan Shea made a motion to table discussion, that council needs more instruction on conflict of interest; needs to get information from the AIDS office about budget before continuing this discussion at its next meeting. Laura Carcagno Guzman seconded the motion.

Voting was as follows:

Hazel Betsey	Yes	Jeff Byers	Yes
Raymond Combs	Yes	John Conley	Yes
Gregory Edwards	Yes	Catherine Geanuracos	Yes
Gene Gowdey	Yes	Laura Carcagno Guzman	Yes
Gary Harrell	Yes	Gene London	Yes
Jim Mitulski	Yes	Susan Shea	Yes
Mary Jane Wood	Yes	Allisa Riker	Yes

Motion Passed 14-0

Susan Shea then stated that the next Implementation and Evaluation Committee needs to set priories for the following: what strategies are there going to be, what is the frame

of reference to cut funds from categories, and how should conflict of interest be highlighted when cutting funding. She also said that they need to ask for money for facilitation and help on what, who, how, and the process of what dollar amount should be cut from which category. Laura Guzman said that the council needs to know what documents they should gather and to look at the evidence. Marcy stated that they should look at outside resource for help. Tom replied that it would be more cost effective to use in house, all members agree.

Adjournment

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January Report - PWA Caucus Meeting

Meeting Date:	January 3, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:00 PM
Members Present:	Cecilia Chung (Co-Chair), Ray Combs, Gary Harrell (Co-Chair), Brad Hume, Greg Neumark, and Robert Whitford.
Others Present:	Richard Bargetto, HIV Consumer Rights Advocacy Project; Steven Feeback, minutes; and Paul Gresham, guest.
Next Meeting:	Wednesday, February 7, 2001, 25 Van Ness, Room 330-B, 5:30-7:00 PM

Welcome and Introductions

Members introduced themselves and formulated the meeting agenda. Ray Combs wants at some point to talk about the SRO Task Force and what it is doing. Rob Whitford called for more training of Council members. He was informed that a training had been scheduled for Saturday, January 20, 2001 from 9 AM to 12 noon. This effort has been planned by the combined efforts of the Membership Committee and Bob Teague of the AIDS Education Training Center. Rob requested that this become part of a regular training series that is offered on a continuous basis to both new and not-so-new members. *Greg Neumark, Cecilia Chung* and *Brad Hume* all spoke up in support of Rob individually and the necessity of better training, something that many Council members are looking for. None of the HIV+ members of the Council want to be treated as statistics or as bodies filling a required number of consumer seats on the Council.

Report from the Consumer Rights Advocacy Project

Richard Bargetto detailed his four new cases from the month of December 2000 *(see attachments)*. He highlighted cases concerning timely communications on the part of a legal services referral agency and the quality of services at a residential facility. Two more clients have lodged complaints against the Derek Silva Community/Catholic Charities. The Harm Reduction Model used in some of the housing facilities came under critical examination by the committee. There are real dangers to residents, including higher risks of fire, theft and violence, which are connected to drug-using behaviors. We feel that this discussion has to be taken to a level of the Council beyond the PWA Caucus. There were quite a few opinions about the advisability of resorting to the usual suggestions for how to address these issues such as a Tenants Association and/or grievances filed with the Consumer Rights Advocacy Project. Many residents have become very fearful about filing anything or speaking up. Many others have become completely apathetic because they believe nothing will get changed. The bottom line, however, is that there are numerous safety concerns.

Tenderloin Community Forum

The community meeting will be held at 201 Turk Street; the cost is a nominal $50. It will still be done in collaboration with the Tenderloin AIDS Resource Center, TARC, and all the service providers in the neighborhood. It will take place on Wednesday January 31st, from 6:30 PM to 8:00 PM. A small form will be distributed in order to gain a little bit of information about the services that are utilized by those attending the forum. The draft of a flyer was also distributed and numerous suggestions made. It will be

revised. Project Open Hand has agreed to distribute leaflets with meals. Larkin Street Youth Services, Continuum, Lyon-Martin Clinic, Tom Waddell Clinic, Glide, and TARC are all part of the outreach plan. *Brad Hume* suggested that the short anonymous form that participants will fill out should concentrate on assessment of services. People who fill out this form and turn it in will get a free food voucher. The food to be served at the forum was discussed, with pizza being seen as the best option and will be served at the beginning. Cecilia Chung will act as MC/facilitator for the evening. She will briefly explain what the Council is and the importance of these forums. *BH* announced that approximately five representatives of the Housing Committee would be in attendance, with someone prepared to give a two-minute capsule of what the committee's mission is. He said that Marc Trotz would also be there to speak about changes in the way emergency housing is handled and the availability of transitional housing opportunities for people with HIV. Hopefully, the other Council committees are also prepared to give **short** presentations as well. Gary Harrell will do it for the PWA Caucus. We anticipate many participants wanting to talk about emergency housing vouchers, but that will not be allowed to dominate the discussion. Richard Bargetto will not be able to be at the forum, but somebody will be there to represent him. The forum will be taped (in a way that is non-obvious) for historical purposes.

Employment Opportunities

Richard Bargetto announced that there are either one or two positions available at the Administrative Assistant level. There is a flexible work schedule. He recommended that anyone interested in working with his office fax a resume to him.

Topics for February Meeting

Cecilia Chung asked this question about the five forums planned to take place each year. Is this objective realistic? She said that if we do decide to do that number during this year, we might want to consider forums that are targeted at certain demographic groups of consumers rather than at certain geographic areas or neighborhoods. She called for further discussion on this. She also recommended that we try to analyze how many members of the Council are in the category of unaffiliated consumers. Is the Council able to meet the coming requirement to have 33% of total membership in that category and 50% in the category of people who are HIV+? *Richard Bargetto* announced that he would be taking a leave of absence starting the first of March and running for three months. He'll enthusiastically return in June. *Brad Hume* asked for some discussion about good meeting process.

Stipends and Reimbursements

Steve Feeback reported that all the forms previously submitted had been turned over to a Council Co-chair. They probably won't be processed, however, as stipends. They would have to be converted into reimbursements for expenses incurred, such as transportation or lost wages. Everyone is entitled to have his case dealt with individually and see if a reimbursement for expenses is in order.

HIV CONSUMER RIGHTS ADVOCACY PROJECT
1540 Market Street, Suite 301
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PWA CAUCUS – DECEMBER 2000 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Pending
2-	Case Management	SFAF	Access to Services	Pending
3-	Housing*	Derek Silva/Catholic Char.	Staff Conduct	Resolved
4-	Case Management	St. Mary's	Staff Conduct	Pending
5-	Housing	Derek Silva/Catholic Char.	Consistent Policy Application	Withdrawn
6-	Mental Health	SFGH Psych Unit (7B)	Quality of Care	Pending

1- Client claims that he not only received unsatisfactory services from UOP dental clinic, but also that after one year his dental needs have not been fully addressed. The client filed a grievance. UOP responded to the client's grievance with a dismissal from the UOP program and a referral to Community Dental. Client is appealing UOP's decision. The Advocacy Project, after referring the client to ALRP based on UOP's possible retaliatory misconduct, is investigating the client's claims as to what are the standards of care for the issues raised in the complaint and whether these standards where breached in this case. Additionally, the Advocacy Project is working with the client to get his outstanding dental work completed by Community Dental.

2- Client arrived in SF and went to the SFAF seeking services. Client raised three issues. First, he claims he was denied service until he could show a diagnosis from a local doctor. SFAF does have a policy that requires a local diagnosis letter; however, SFAF will provide services for 30 days while client obtains this verification. Client has obtained the letter and services have been rendered. Second, client claims to have received erroneous information about HIV services in SF. After speaking with additional staff, correct information has been communicated to client. Third, client claims he was assigned to an unresponsive case manager. After an Advocacy Project inquiry, the client did receive communication from his case manager; however the client believed this communication to be unsatisfactory. The Advocacy Project is assisting the client with the grievance about the standard of care for case managers and whether this standard was breached in this case.

3- Client alleges that another Derek Silva resident harassed him and staff was unresponsive after being notified. Advocacy Project attempted to mediate the dispute, but was unsuccessful due to the other resident's failure to participate in the mediation in good faith. The Advocacy Project assisted the client in filing a grievance as to the standard of care for housing programs to protect clients from other residents and whether that standard was breached in this case. The Director of HIV Services for Catholic Charities responded and confirmed the numerous attempts for reconciliation between residents by staff and that the client was placed on a waitlist for a room change. Advocacy Project referred client to ALRP for possible harassment charges in the problem persists.

4- Client claims that he was discharged from St. Mary's dementia ward without any transition plan, except for a referral to Continuum. The Advocacy Project is conducting an inquiry into the allegations as well as what is the standard of care for discharge of a mental health patient and if that standard was breached in this case.

5- Client claims that his guest was denied entrance into the building for no apparent reason. Client claims other guests are freely admitted and has filed a grievance based on inconsistent policy application. Client filed a grievance regarding the Derek Silva visitor policy and the Program Manager promptly responded. Although client is dissatisfied with the response, client has decided not to pursue the issue further.

6- Client claims that he was treated without professional care while a patient at the Psychiatric Unit (7B) at SFGH. Client filed a grievance that included allegations of sexual harassment, breach of confidentiality, unprofessional staff conduct, false imprisonment and custodial negligence of personal property. SFGH responded with a brief reply; however, their response did not indicate whether an investigation was conducted, or what, if any, was the outcome of the inquiry. The Advocacy Project recently appealed SFGH's original response asking for more information on the ten issues concerning standards of care regarding staff conduct and whether they were breached in this case. SFGH is conducting an internal inquiry into the allegations.

NEW CASES

	Service	Agency	Issue	Outcome
1-	Legal	ALRP	Quality of Care	Pending
2-	Housing	Catholic Charities	Quality of Care	Pending
3-	Housing*	Catholic Charities/Derek Silva	Quality of Care	Pending
4-	Housing*	Catholic Charities/Derek Silva	Quality of Care	Pending

1- Client claims that he requested legal services from ALRP regarding an insurance law issue and was promised a referral. After many weeks, client claims he received no response from ALRP and continued to call them. Client claims that only after intervention by the Advocacy Project did he receive a response from the ALRP that they could not locate an attorney for him. Client filed a grievance regarding what is the standard of care for client communications and also what is the

ALRP's scope of services. The ALRP responded to the grievance stating that they have a communications policy to respond to all clients within 24 hours. However, certain cases, like the insurance case that the client presented, have to be waitlisted for an attorney referral. Because of the client's grievance, the ALRP promised to improve communications with clients by now providin written communications in the future.

2- Client filed a grievance with Catholic Charities regarding a breach of professionalism from a staff social worker. Client believes the social worker was disingenuous about scheduling issues and was not flexible in accommodating the client's needs. After repeated attempts to communicate with client, Advocacy Project has withdrawn the grievance through client inaction.

3- Client filed a grievance claiming that another resident at Derek Silva entered his apartment without his consent. Client's assertions are based on his perception that some items appeared to have been moved. Client is awaiting a response from Derek Silva staff as to how they plan on dealing with his safety concerns. Advocacy Project is assisting client with the grievance and monitoring Derek Silva's response.

4- Client claims that he was stuck in the elevator at Derek Silva for nearly two hours with little communication from staff. With the assistance of the Advocacy Project, client filed a grievance asking for Derek Silva to develop an elevator malfunction response policy as well as investigating the delay and alleged unprofessional conduct by desk staff workers. Advocacy Project is assisting client in monitoring Derek Silva's response.

* Duplicated Client

Referral Calls:		
	Derek Silva Grievance Procedures	1
	Hazel Betsy Grievance Procedures	1
	Community Dental Grievance Procedures	1
	Walgreen's Customer Service	1
	ALRP Legal Services	3
	Total	7

Total Volunteer UOS: 0

fires
theft
violence

(Report prepared by Richard Bargetto on 1/2/00)

DRAFT

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122
2
1/22/01
draft

Minutes, January 22, 2001 HIV HEALTH SERVICES PLANNING COUNCIL
Draft until approved by Council at its next meeting

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I. Call to Order
4:40 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda was revised, and then adopted by consensus.

IV. Review and Approval of Minutes, 12/18/01 – Vote
12/18/01 Council Meeting Minutes – No changes or corrections were requested. It was moved and seconded to approve the draft of these minutes; the motion passed by a unanimous vote with two abstentions.

V. General Announcements
Rob Whitford requested that the Council re-look at The Harm Reduction law which he said he voted in favor seems to protection is there for the abuser in his opinion. Fires, theft and violence on a daily basis threaten those that are not using. He felt that since he was a new member and had not had a lot of time to consider all the consequences, and wanted to put it out for the council to re-think this issue.

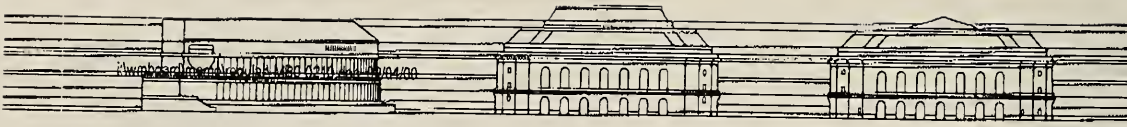
Gary Harrell wanted to speak briefly with one individual from each committee about the Forum during the break. He asked for a show of hands of who will be participating in the Forum.

VI. Public Comment
Ron Lewis from Seattle with the Regeneration Project, a new Non Profit Organization came to introduce himself. He shared that the focus and mission of the organization is to provide scholarships for Colleges and University. They will also provide a Counseling Program, Advocacy Program, and an Abstinence Support Program. He shared brochures with the council.

Jose Villarce, a visitor, announced that he was interested in participating as a member of the Council. Laura welcomed him and asked that he submit an application.

VII. Reports
San Francisco Department of Public Health:
Laura Thomas presented. She announced the Title 1 Award from HRSA (Health Resources Service Administration) for San Francisco EMA (Eligible Metropolitan Area) for the FY 2001 would receive $35,771,651.00, which is an increase from last year of $525,174.00, which is about a 1.5% increase. Out of that increase, the Congressional Black Caucus (The Minority AIDS Initiative Dollars) is $472,779.00 which is an increase of $117,000.00. This is earmarked for new Projects. The Department of Public Health will be coming back with an in depth analysis of what these numbers mean. There are a number of larger issues that need to be taken into account. By the latest, the first part of March, The AIDS office will be able to give a better report on what this actually means for services.

This is all good news and the bottom line is it is better news than what was expected and a sign that the Council and the Health Department are doing a good job of maintaining a continuum of care for people with HIV.



HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

Feb. 26, 2001 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes, 1/22 — VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *SF Department of Public Health*	**4:55 PM**
	• *Responding to Racial & Ethnic Disparities in HIV Care (Part 2)*	**5:00 PM**
	Immigrant Populations (Positive Resource Center, Immigrant HIV Assistance Project and Clinica Esperanza)	
	• *Tenderloin Community Forum Report-Back*	**5:45 PM**
	• *HIV Consumer Rights Advocacy Project Summary Information*	**5:50 PM**
	Presentation by Richard Bargetto	
Break		**6:00 PM**
	• *Steering Committee*	**6:20 PM**
	- Bylaws Revision Language	
	• *PWA Caucus*	**6:35 PM**
	• *Implementation & Evaluation Committee*	**6:40 PM**
	- Prioritization Plan: A Proposal for an Organizing Committee	
	• *Housing Committee*	**7:05 PM**
	• *Membership Committee*	**7:15 PM**
	- Nominees — **VOTE**	
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming schedule of dates/meetings:

Day	Date	Type of meeting	Location	Time
Mon	3/5	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	3/7	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	3/7	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	3/12	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Thurs	3/15	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	3/19	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	3/26	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	4/2	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	4/4	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

Membership Committee January Report

Meeting Date: January 18, 2001

Meeting Place: 25 Van Ness Ave., Room 330-A

Meeting Time: 5:30 to 7:00 PM

Members Present: Laura Carcagno Guzman, Ken Pearce, Janis Takamoto, and Bob Teague

Others Present: Steven Feeback, minutes; Toni Butler, nominee; and Derrick Mapp, nominee.

Next Meeting: Thursday, February 22, 2000, 25 Van Ness, Room 330A, 5:30-7:00 PM
Meetings will generally be held on the 3rd Thursday of each month.

Introductions

Discussion with Nominees

Ken Pearce asked Toni Butler to go first and present some information about background and areas of interest. Jeff Klausner sparked her curiosity about the Council and then she was put in touch with Janis Takamoto, who explained some of the membership dynamics. She is the Coordinator for the CARE-funded program at City Clinic. That is part of her job as Manager of the Clinic. The past year has been pretty much full time learning about as well as managing care for the HIV+ clientele at the Clinic. She would welcome the additional background to be gained by working with the Council. She has a long history of working in healthcare settings, including most of the hospitals in San Francisco. *Laura Carcagno Guzman* explained the time commitment required of Council members, and how this increases during the period we call Prioritization. Toni referred to some of the other councils and work groups to which she dedicates a portion of her time. She has been appointed to work on obtaining greater collaboration between Managed Care Organizations and Public Health. This is a large project and is just getting underway. There is potential for the Council's work and this project coinciding but there is also the potential for some time conflicts. *LCG* asked about Toni's work in communities of color. She replied that another project she has been asked to work on is related to health issues in the Bayview-Potrero Hill area of the City. She said some STD rates at City Clinic had been consistently higher for those residents. She has seen basically no change during her six years at the clinic. She wants to address this problem with home parties based on sexual health awareness for women of color.

KP asked Derrick Mapp to go next. He has a great deal of knowledge about the Council from his time working as an administrative support person. He currently works as an Assistant Case Manager for the African AIDS Network, which does not receive funds from any local source. He also helps facilitate a peer-to-peer support group at the Shanti Project and a music group at AIDS Health Project. Both are volunteer positions. These are the only services he utilizes which have some relation to the CARE Council, other than the ADAP program. In the past he was a recipient of a greater number of services than at the present. His current job brings him into contact with some 100 clients receiving long distance case management services, including access to medical treatments that are derived from surplus medications. African AIDS Network is affiliated with six medical associations working at the grassroots level in six African nations. He has the support of his employer to take part in the work of the Council. *LCG* asked Derrick about his past experience with services and how that experience has shaped the way he understands his present participation in shaping the system of care and prioritizing service categories. He responded that he has concerns, growing from the period after moving from New York to San Francisco, about requirements that some service providers are utilizing to screen out clients who are not "sick enough," and/or do not have an AIDS-defining diagnosis. He faced many challenges in his efforts to overcome homelessness and get some economic stability.

Recruitment Process and the Membership Committee

Janis Takamoto asked for clarification about the process and whether or not it is required that someone attend a Council meeting before coming to talk with the Membership Committee. It was agreed that this would become the established procedure and that it would be clarified in the written procedures, if needed. It was viewed as a sensible process allowing prospective members the chance to become acquainted with the Council's agendas, its discussions and its structure before going further in the recruitment process.

Analysis of Current Membership and Areas of Representation

Recent memos from Laura Thomas were reviewed. She has been analyzing the latest language in the Reauthorized Ryan White CARE Act and applying these new principles to our current membership. In this process she has come to believe that we have a lower number of unaffiliated consumers than she had previously estimated. This is now being interpreted to mean that 33% of the membership must satisfy two distinct criteria: to not be affiliated with any agency AND to be a consumer of services that are CARE funded. Everyone agreed that more up-to-date and precise information must be gathered from the current Council membership. However, Laura Thomas has done some preliminary analysis and determined that only seven members satisfy both of the criteria. It should be about 13 members. So, this goal means putting almost total concentration on recruitment of unaffiliated consumers. Members wanted additional clarification about the definition of consumers: How is ADAP considered? Just Title I CARE services? Is the past year a good time period for evaluating a member's utilization of services? Who is unaffiliated? Are there people who have declined to reveal their HIV status? Even though we have approximately 50% membership of HIV+ people, there appears to be a distinct shortage of unaffiliated consumers of services.

New Member Recommendations.

Three prospective members were approved by unanimous vote of the Membership Committee at its last meeting and will be put before the Council at its meeting January 22. This month the Committee wanted to also add its approval of Derrick Mapp. By the time these minutes are published, these four will have been voted up or down by the full Council. The Committee would like Toni Butler to have a chance to attend a full Council meeting, then would like to have further conversation with her. *Bob Teague* asked if the biographical information about nominees could be distributed to the membership before the monthly meeting. *LCG* asked staff to look up the dates of appointment for current members. It turned out that John Conley's term of appointment is up in the month of February. He will now need to reapply. The terms of appointment for Sam Kaplan and Laura Carcagno Guzman will then be up in March. We should establish some procedures for reappointment.

Orientation and Training

BT said the first member training was to be two days after this meeting, on Saturday January 20, 2001 at 9:00 AM in room 330, 25 Van Ness Ave. It is being done as the first of many Technical Assistance workshops to be presented in collaboration with the Membership Committee and presented by the AIDS Education Training Center. Bob presented his latest revision of the TA plan, containing a series of trainings, such as a session focused on group process, bylaws and procedures.

Bylaws Changes due to Language in Reauthorized CARE Act

LCG reported that Laura Thomas and Michelle Long Dixon had been working on some suggested Bylaws revisions. A small ad-hoc group will be working on this for the Council.

Attendance and Compliance Issues

Several Council members have been violating the minimum mandatory requirements for the past quarter and in some cases the past few quarters. They will get phone calls from someone on the Membership Committee.

HIV Health Services Planning Council
Steering Committee

February Report

Meeting Date:	Monday, February 12, 2000, 5:00 – 7:00 PM
Members Present:	Jim Mitulski, Council Co-Chair; Gary Harrell, PWA Caucus Co-Chair; Brad Hume, Housing Comm. Co-Chair; Greg Nuemark; Susan Shea, I&E Comm. Co-Chair; Bob Teague and Rob Whitford
Others Present:	Michelle Long Dixon, Laura Thomas and Russ Zellers, DPH, plus Derrick Mapp, Council nominee and Steve Feeback, minutes
Next Meeting:	Monday, March 12, 2001 25 Van Ness, 5th Floor Conf. Room, 5:00 – 7:00 PM

Call to Order

Bylaws Revisions
Several proposed changes are being drafted and will be presented in written form at the next Council meeting. The intent is to give sufficient time for members to consider the language. Therefore, changes are not voted on until the subsequent meeting.

Presentations for 2/26 Council Meeting
Laura Guzman is coordinating the speakers for the major subject to be presented in the first half the agenda. Richard Bargetto will give a presentation as well. Gary Harrell will also give a report-back about the Tenderloin Community Forum in the first half the agenda.

Long Range Plan
Laura Thomas ran through the schedule of upcoming meetings, including her plan to attend the next PWA Caucus meeting.

IEC Report
Susan Shea proposed that the I&E Committee take time to put forward a proposal for a Prioritization Organizing Committee. That idea got strong support.

Membership Report
Under this topic came discussion of Council member education. Bob Teague of AETC has done a successful new member orientation and has planned future trainings. This will be discussed further in the future.

PWA Caucus Report
Gary Harrell said the PWA Caucus had endorsed a motion by a vote of 6-0-1 concerning the Reimbursement policy for claiming lost wages. This issue will now be referred to a meeting set up by Jim Mitulski. It will include members of the PWA Caucus and representatives of the Council Support contractor, Positive Resource Center.

Adjournment
Jim Mitulski adjourned the meeting.

February Report - PWA Caucus Meeting

Meeting Date:	February 7, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:00 PM
Members Present:	Cecilia Chung (Co-Chair), Ray Combs, Gary Harrell (Co-Chair), Brad Hume, Greg Neumark, Ken Pearce, and Robert Whitford.
Others Present:	Richard Bargetto, HIV Consumer Rights Advocacy Project; Herbert Cintron, guest; Steven Feeback, minutes; Christopher Scott Gambia, guest; John McLaughlin, guest; Wayne Peace, guest; Ralph Torres, guest; and Salvador Vera, guest.
Next Meeting:	Wednesday, March 7, 2001, 25 Van Ness, Room 330-B, 5:30-7:00 PM

Welcome and Introductions

Members introduced themselves and formulated the meeting agenda.

Membership Composition

Ken Pearce, Chair of the Membership Committee, talked about the drive to recruit prospective members for the Council, specifically those who are consumers of services AND unaffiliated with any CARE funded agency. Pursuant to new HRSA/legislative requirements, the revised Council Bylaws will likely provide that a minimum of 33% Council membership be consumers who are unaffiliated. At full strength (40 members), 33% of the Council would translate into 13 people filling this category of seats. *Greg Neumark* argued for raising the required level of HIV+ people on the Council to 60% rather than 50%. *Richard Bargetto* requested that the Membership Committee examine its files; he believes that someone he referred about a year ago was not contacted after applying.

Prioritization

In an effort to share information between Council committees, *Steve Feeback* reported to the Caucus about discussion on this topic in the Implementation & Evaluation Committee two days prior. He reported that this process done every two years by the Council would be taking place from February through August. This year will be handled differently than two years ago. A proposal will soon be brought before the Council to empower a Prioritization Organizing Committee to guide the process. Representation and participation from the PWA Caucus is extremely important and can constitute a key role in the overall process. *GN* made a plea for meetings to start at 5:30 PM in order to accommodate work schedules.

PWA Caucus meeting day/time

There was brief discussion about this meeting being on the same day as the Housing Committee. This causes a long day for some of those who attend both meetings and may prevent the Housing Comm. from even considering a move to later hours after work-time. *Brad Hume* said he views it as crucial for the work of the Housing Committee that a significant number of DPH staff as well as housing service providers take part in the meetings. Their presence is very helpful. In the past, he said, the Housing Committee attempted to move the time of its meeting until after 5 PM. But they experienced a decline in the number of people

attending from those groups, without seeing a corresponding increase in attendance from Council members, especially HIV+ members and consumers of services. *Cecilia Chung* suggested the possibility of changing the PWA Caucus to the second Wednesday of the month. The change won't take place before further discussion in both committees; so not before April.

Debriefing the Tenderloin Community Forum

CC started the discussion by thanking everyone who participated and helped with the logistics. She expressed her excitement about how well the forum went and how good the turnout was. She felt that we helped mobilize the Tenderloin community and bring complaints about SRO housing to the forefront. Tenderloin AIDS Resource Center (TARC) has an initiative underway with the Housing Rights Committee to continue the process of mobilization. Other service providers in the neighborhood collaborated with the Community Forum by mobilizing their clients and frontline staff to attend. These included Larkin Street Youth Services, the Native American AIDS Project, Continuum, Lyon-Martin Clinic, Tom Waddell Clinic, and Project Open Hand. *BH* said he heard testimony and saw photos about things that were very depressing, yet he left the Forum feeling energized. It was a huge success, with Housing conditions being the number one, most pressing issue. *Ray Combs* added his affirmation, while offering a critique about being sure to call on people in the back who had their hands up wanting to speak. *Gary Harrell* said that perhaps the Council's representatives ended up talking a bit too much; perhaps we could have heard more from the community. *BH* thought the interaction between Council members and Consumers was very positive. *Rob Whitford* and others recommended investing in a microphone to use at future events. *CC* said she was impressed that the community was speaking up with passion and good ideas. She commented that almost all the attendees stayed until the end. About 75 food vouchers were given out at the end to those who stayed. The raffle was a big success. Three people asked for further information about possibly being appointed to the Council. Cecilia also felt that the PWA Caucus should develop some sort of strategy to respond to the community input we heard that evening. Christopher, from Native American AIDS Project, took part in the Forum and offered a positive evaluation. He was left feeling a need for more community meetings. There was brief discussion about the frequency of these events by the Council and the methods of getting community input. We do need to be involved in the issues related to SRO housing conditions. Hopefully, the Board of Supervisors is ready to tackle these problems. Some members wanted definite follow-through on the issues from this forum. Other people wanted to start planning the next one. This was not fully resolved, but everyone was reassured that a summary would be written and a report from the forum will be scheduled for the next Council meeting. This will then become part of the process, which examines the Councils priorities or goals for the next two years of work. *Richard Bargetto* said that he has received a very significant number of complaints about the SRO hotels, but he is totally limited in what he can do for clients. He can only make referrals. Probably the important thing we can all do on a citywide level is to raise our voices individually and collectively. The Housing Committee would want to be involved as well. Members had a natural resistance to scheduling an upcoming forum until this one had been more fully examined.

Meeting Dynamics

BH called for more structure and focus in the meetings of the PWA Caucus. Several ground rules were suggested. The Co-chairs will work on doing an advance agenda, while maintaining an open agenda. *CC* called for more phone and email communications with the Co-chairs in between meetings. *GH* feels the need for flexible structure. *GN* and *RC* talked about compromise ideas and some middle ground. Most people wanted time limits on discussion. *CC* encouraged members to continue the discussions after the meeting by communicating more regularly. Both Co-chairs are relatively new in this position. She wants people to continue making suggestions. The meeting dynamics can evolve in a constructive way if we agree to continue the conversations.

Report from the Consumer Rights Advocacy Project

Richard Bargetto provided his report covering the month of January 2001 *(see attachments)*. In the interest of saving time he just passed it out.

Language in the Long Range Plan

Greg Neumark asked if other members had problems opening or downloading the email document. Those who had seen the draft being circulated said this may be an incomplete draft, but if this is it then the points discussed by the PWA Caucus didn't make it into the Plan. Members of the Caucus are extremely interested in the Long-Range Plan. It is probably a draft at this stage and several members expressed a desire to be involved in a second draft. *GN* again articulated the importance of ensuring that our values get reflected in this Plan. This is just as important as the Prioritization. We had identified some very important issues and they should be noted. More on this at the next meeting.

Reimbursements Policy for Lost Wages

Greg also wanted some further discussion on this issue, which has dragged out for about eight months. He wants input from the PWA Caucus about the standards for proof of lost wages. He wants this issue brought back to the Steering Committee with someone representing our views in that meeting. Many members support the concept of providing incentives for participation. *Ray* wants to see creativity applied to this policy-in-the-making. *Richard* said that the issue is whether Greg has to provide a document about lost wages or if this can be self-reported. *Brad* made a motion that the policy on lost wages follow a procedure of self-reporting as long as the member is able to fulfill the minimum attendance requirements of the Council. Members expressed their views about the amounts per meetings and per month. It was asked where the money comes from in the Council's budget. *Richard* said that there is a line item in the Council support budget for reimbursements. There was discussion about comparing these lost wages with Consultants hourly rates and with wages of support staff working for the Council. The cap was decided to be $30 per meeting, $60 per month. With seven Council members present, six voted in favor, 0 opposed and one abstention.

Tenderloin Community Forum
January 31, 2001
201 Turk Street Apartments

Meeting opening and Welcome by Cecilia Chung. She explained that the purpose of the Forum was to get feedback from consumers. Also, to inform consumers of the Prioritization Activities for the fiscal year 2002-2003. She explained how the information received from this forum would be used to help with Prioritizing Services and making allocations of funds in the next fiscal year.

Cecilia then introduced Laura Guzman the Co Chair of the Planning Council. Laura gave a brief synopsis of the Planning Council and its goals. She then introduced other Planning Council members and nominees in attendance: Brad Hume, Margot Antonetty, Ray Combs, Hazel Betsey, Janis Takamoto, Carmen Madriz, Derrick Mapp, Rob Whitford, Catherine Geanuracos, Gary Harrell, Kenny Landes. Susan Shea was introduced a little later in the program.

Community Members shared their concerns:

Dental Care Issues –

- Treatment of Patients by Staff
- Unclear of Protocols
- Unclear how to correctly gain access to care, finding out who serves patients with Medi-Cal or Medicare versus Private Insurance.

Back to Work Issues –

- Unclear of Protocol

Housing Issues

- Some SROs are not up to Earthquake or Fire Code
- Unhealthy Living Conditions:
    1. Roach and Rat invested living conditions
    2. Fungus Growing on walls
    3. Deplorable Furnishings in Furnished Apartments
    4. Landlords stealing furniture and selling to other tenants.
    5. Blatant Unaccountability of some SRO Properties.

***One consumer brought in a poster with pictures of her room in which a fire happened while she was at work. She explained that the Landlord did not call the Fire Department or the Police. She was called by a neighbor and told that her apartment was on Fire. When she got to her apartment, to see what was salvageable, the mattress was turned over and rats had been living in the mattress. There were pictures of baby rats and feces everywhere.

Council members pointed out how effective and powerful these pictures were by presenting concrete evidence. Suggestions were made by other consumers to pursue class action lawsuits. One Client explained how this was affective in the SRO in which he resides. He explained how the elevator was always out of order. The tenants as a group filed a Class Action suit. After that a new elevator was installed and other matters regarding this SRO hotel were brought up to code. AIDS Legal Referral Panel, Housing Rights Assistance Programs and HIV Consumer Rights Advocacy Project were potential legal resources that Laura Guzman suggested consumers can contact for assistance.

Susan Shea responded to concerns regarding limitations some providers are faced with regarding the type of insurance benefits one may receive. She explained that the Ryan White CARE Act allows for specific types of expenditures and contains rigid guidelines. She talked about the way " wrap-around dollars" fill the gaps in other services. She sees it as understandable how one could find it difficult to know where one is allowed to get care, which is determined by the form of insurance, be it either Medi-Cal/Medicaid or Private Insurance.

Pizza was served throughout the Forum, door prizes were raffled off and shopping vouchers were given to the participants. A survey was administered and the results are:

Gender: Female:7 Male:55 Transgender:5 Other: Indicated BI or Two Spirits:4

Age Range: 15-25: 9 26-35: 12 36-40/: 19 41-66: 28

Ethnicity: White:29 AA/Black:24 Hispanic/Latino:5 Native American:6 Other:6

HIV Status: Identified as Positive:50 Identified as Negative:15 Identified as Care Giver:1 Identified as don't know:5

Services Used:

Healthcare-Medical – 39 consumers
W.M./16 B.M./9 W.F./1 B.F./3 L/H.M./2 N.A.M./1 N.A.F./1 Other Male/2 TG/4

Case Management: – 37 consumers
WM./15 B.M./6 W.F./2 B.F./2 L/H.M./2 N.A.M./2 Other M./3 TG/4

Substance Abuse Program – 31 consumers
W.M./10 B.M./8 W.F./0 B.F./4 L/H.M./4 Other M./1 TG/4

Mental Health – 26 consumers
W.M./14 B.M./4 W.F./0 B.F./1 N.A.M./2 L/H.M./1 Other M./2 TG/3

Dental Care – 24 consumers
W.M./10 B.M./6 W.F./0 B.F./3 N.A.M./0 L/H.M./2 Other M./1 TG/3

Money Management – 23 consumers
W.M./12 B.M./5 B.F./1 W.F./0 N.A.M./1 Other M./1 TG/2

Housing Services – 32 consumers
W.M./12 B.M./6 B.F./4 W.F./0 N.A.M./2 L/H.M./2 Other M./3 TG/3

Food Service – 45 consumers
W.M./17 B.M./12 B.F./4 W.F./0 N.A.M./1 L/H.M./3 Other M./ N.A.F./1 TG/4

Transportation – 23 consumers
W.M./8 B.M./5 W.F./0 B.F./2 L/H.M./2 N.A.M./1 N.A.F./1 Other M./2 TG/3

Legal Services – 11 consumers
W M/5 B.M./2 B.F./1 N.A.M./1 TG/2

Comments at the bottom of the surveys included brief statements about the services mentioned above as well as viewpoints about "shared values," such as a desire to be treated fairly, have affordable housing available, and have access to information.

Another way of presenting the statistics is in the form a chart:

Gender			
Female 7	Male 55	Transgender 5	Other: indicated as BI or Two Spirits or gave no response 4

Age Range	15-29	26-35	36-40	41-66	41-66
	9	12	19	28	28
Ethnicity	Caucasian	African American/Black	Latino/ Hispanic	Native American	Other
-	29	24	5	6	6

HIV Status	50 Identified Positive	15 Identified Negative	1 Identified as Care Giver	5 Identified as " Don't Know"

Services Used	Total Response	White Male	Black Male	White Female	Black Female	Hispanic/Latino Male	Native American Male	Native American Female	Other	Transgender
Healthcare Medical	39	16	9	1	3	2	1	1	2	4
Case Management	37	15	6	2	2	2	2		3	4
Substance Abuse Program	31	10	8		4	4			1	4
Mental Health	26	14	4		1	1	2		2	3
Dental Care	24	10	6		3	2			1	3
Money Management	23	12	5		1		1		1	2
Housing	32	12	6		4	2	2		3	3
Food	45	17	12		4	3	1	1		4
Transportation	23	8	5		2	2	1	1	2	3
Legal	11	5	2		1		1			2

HIV CONSUMER RIGHTS ADVOCACY PROJECT
1540 Market Street, Suite 301
San Francisco, CA 94102
Tel: 415.863.8131
Fax: 415.863.0831

PWA CAUCUS – JANUARY 2001 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Pending
2-	Case Management	St. Mary's	Staff Conduct	Pending
3-	Mental Health	SFGH Psych Unit (7B)	Quality of Care	Pending
4-	Housing*	Derek Silva - Catholic Charities	Quality of Care	Pending
5-	Housing*	Derek Silva – Catholic Charities	Quality of Care	Pending

1- Client claims that he not only received unsatisfactory services from UOP dental clinic, but also that after one year his dental needs have not been fully addressed. The client filed a grievance. UOP responded to the client's grievance with a dismissal from the UOP program and a referral to Community Dental. Client is appealing UOP's decision. The Advocacy Project, after referring the client to ALRP based on UOP's possible retaliatory misconduct, is investigating the client's claims as to what are the standards of care for the issues raised in the complaint and whether these standards where breached in this case. Additionally, the Advocacy Project is working with the client to get his outstanding dental work completed by Community Dental.

2- Client claims that he was discharged from St. Mary's dementia ward without any transition plan, except for a referral to Continuum. The Advocacy Project is conducting an inquiry into the allegations as well as what is the standard of care for discharge of a mental health patient and if that standard was breached in this case.

3- Client claims that he was treated without professional care while a patient at the Psychiatric Unit (7B) at SFGH. Client filed a grievance that included allegations of sexual harassment, breach of confidentiality, unprofessional staff conduct, false imprisonment and custodial negligence of personal property. SFGH responded with a brief reply; however, their response did not indicate whether an investigation was conducted, or what, if any, was the outcome of the inquiry. The Advocacy Project then appealed SFGH's reply asking for more information regarding concerning standards of care for staff conduct and whether they were breached in this case. SFGH then conducted a further internal inquiry and again provided a general response. The Advocacy Project has now requested more specificity to this second response.

4- Client filed a grievance claiming that another resident at Derek Silva entered his apartment without his consent. Client's assertions are based on his perception that some items appeared to have been moved. Client is awaiting a response from Derek Silva staff as to how they plan on dealing with his safety concerns. Advocacy Project is assisting client with the grievance and monitoring Derek Silva's response.

5- Client claims that he was stuck in the elevator at Derek Silva for nearly two hours with little communication from staff. With the assistance of the Advocacy Project, client filed a grievance asking for Derek Silva to develop an elevator malfunction response policy as well as investigating the delay and alleged unprofessional conduct by desk staff workers. Advocacy Project is assisting client in monitoring Derek Silva's response.

NEW CASES

	Service	Agency	Issue	Outcome
1-	Housing	SFAF	Subsidy Denied	Resolved
2-	Housing	Derek Silva – Catholic Charities	Underutilized Housing	Pending
3-	Housing	Derek Silva – Catholic Charities	Breach of Confidentiality	Pending
4-	Housing	Derek Silva – Catholic Charities	Eviction	Resolved

1- Client was referred from the HWL to SFAF for a subsidy. During the referral intake process, client self-reported that she was in a partnered relationship and then was denied a subsidy due to her partner's income. Client contacted Advocacy Project and self-reported that although she was living with her friend to avoid homelessness, she did not consider herself in a partnered relationship. In fact, client claims she was trying to get out of the relationship because it included domestic violence. Advocacy Project contacted SFAF and HWL. It was agreed that client could change her status from "partnered" to "single" which more clearly reflect the nature of her relationship with her friend. Client now qualifies for the subsidy and will be re-referred when available. Client is satisfied with outcome.

2- Client claims that he & his partner have applied for a two bedroom at Derek Silva many months ago while some single residents are living in a two bedrooms. Client filed a grievance as to the policy regarding two bedroom apartments and what mechanisms are in place so that the decision for housing couples are made fairly for all residents. The Advocacy Project assisted the client with the grievance and has requested a response from Catholic Charities.

3- Client claims that his case manager staff violates other residents' confidentiality by revealing private and confidential information. Because of such alleged breaches, client does not trust the staff and has selected not to receive case management services on site. The Advocacy Project assisted client in filing the grievance and is awaiting a response from Catholic Charities.

4- Client was served with a 10-day eviction notice based on nuisance allegations. Advocacy Project intervened and negotiated a three-month stay so that the client can find appropriate housing. Although the client does not agree with the nuisance allegations, he is satisfied with the outcome.

* Duplicated Client

Referral Calls:		
	SFGH Grievance Procedures	1
	Ferguson Place Grievance Procedures	1
	API Wellness Center Grievance Procedures	1
	Derek Silva Grievance Procedures	1
	Mission Neighborhood Case Management Services	1
	T. A. R. C. Case Management Services	1
	ALRP Services	2
	Total	8

(Report prepared by Richard Bargetto on 1/25/00)

February Report
Housing Committee

To:	Members, HIV Health Services Planning Council
Meeting Date:	February 7, 2001
Meeting Place:	25 Van Ness Ave., Room 330-A
Members Present:	Ray Combs, Fernando Gomez-Benitez, Brad Hume (Chair), Ken Pearce and Ali Riker
Others Present:	Denise Albano, Larkin St. Youth Center; Chris Callandrillo, CCSAF; Carol Carbone, TARC; Amy Cunninghis, SFAF; Elizabeth Colomello, SFRA; Steven Feeback, minutes; Christopher Scott Gamova, Native American AIDS Project; Dana Van Gorder, SFAF; Kevin Johnson, staff; Daisy Leyva, DPH (Housing); George Simmons, CCASF; Pam Sims, SFRA; and Marc Trotz, DPH (Housing).
Next Meeting:	Wednesday, March 7, 2001, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Steve Feeback informed members of the Committee about his personal struggle with an eviction. As a resident of San Mateo County (Daly City), he is experiencing what it means to have no tenant's rights. Several members offered suggestions.

Tenderloin Community Forum Update

Brad Hume reported that it was a big success. About 75 people attended and stayed for the whole evening. He mentioned some of the concerns expressed by consumers. The number 1 issue had to do with affordable housing options and the poor condition of SRO hotels. A more complete report is being produced by Council staff.

Information from SFAF

Amy Cunninghis reminded members that the San Francisco AIDS Foundation had been instrumental in providing information to the Board of Supervisors about how under level funding the subsidies get reduced anyway due to rising rents and "fair market rates." She suggested some discussion and planning for a similar effort this year. The Board may have improved and may want to do more to address the quality and the affordability of housing for people with AIDS. The bottom line is trying to maintain the number of subsidy slots. Advocacy efforts are in the planning stages. Dana Van Gorder elaborated strategies for pressing San Francisco to devote more resources to the housing subsidies. George Simmons advocated for raising the number of Catholic Charities partial subsidies to 200. They have large waitlists. Many clients are homeless or near-homeless. Others are marginally housed at SROs. Rising utility bills are about to have a huge impact. This is the time for advocacy efforts to get organized.

HOPWA Update/Capital Improvement Projects

The audio tape was not at all clear, but fortunately the representatives of San Francisco Redevelopment Agency brought a very detailed written report with them. *Please see attached.* The RCF-CI facilities require a fair amount of support services, some of which is coming out of HOPWA funds, and some out of CARE funds. HOPWA funds are also used for capital projects, building new units in other words; whereas CARE funds cannot be used for building or renovation.

Workplan: Goals & Objectives

Staff will try to locate the document previously drawn up as an outline of the committee's goals and objectives.

SRO Housing Discussion

Marc Trotz talked about how to help channel the advocacy of consumers like those who attended the Forum and to help link them up with allies who also want to see change in the housing situation, specifically in SROs. Complaints are real, but San Francisco doesn't want to deal with it. *George Simmons* expressed dismay with the complaints falling on deaf ears. *Fernando Gomez-Benitez* said the SROs will not improve until there are new, effective enforcement mechanisms. He explained that there is an historical feud between the City Attorney's office and the Department of Building Inspections. We know the limitations, but raising our voice is the most important thing we can do. He mentioned the possibility of a Tenderloin SRO Collaborative, similar to the one operating in the Mission. The problem is overwhelming in both areas, but they feel the Mission is more or less on the right track. He is somewhat optimistic about the new Board of Supervisors. We have to keep pushing things forward and make things happen, both with funding and policy change. *Brad Hume* referred again to one of the consumers who attended the Forum, bringing a poster of photos that depict the unsanitary, uninhabitable condition of her SRO room. He knows that, for the most part, people don't feel empowered to complain, much less take photos. And, it's a challenge to get the articulate consumers like her together with the people who can help advocate and the people who can bring about change. The Housing Rights Committee is beginning to work out of TARC's offices, with regular Monday afternoon office hours. He suggested working on a plan or a strategy for what the Housing Committee can try to accomplish. Carol Carbone said that a number of her clients are interested in taking photos, but her question is what do you do with the photos. She points to a structure in which the penalties for code violations are so low. Lawyers don't seem interested in class action based on habitability issues. The building codes have hundreds of loopholes. It's easy for the owners to get off the hook on code violations. *FGB* said that the flashpoint for organizing and tenant mobilization at the Julian Hotel was when a baby got bitten by a rat. Newspaper coverage followed. But that has to be followed by testimony before the Board of Supervisors in order to get the loopholes closed. There's no other way. It's still "disposable people" up against people with influence. We have to encourage more of the clients and tenants to take it to the Board of Supervisors. Both the clients with HIV and the clients with mental health diagnoses are using the SRO hotels. We need coordination of advocacy efforts. The Housing Committee had said it wanted to track complaints against the SROs. *Ali Riker* wondered if ALRP has been able to do that.

CARE Council Priortization

The I & E Committee is spearheading this effort and wants to begin with an overall understanding of the care system, a system in which Ryan White CARE Act Funds are but a piece. This will be explained further at the next Council meeting. Housing issues should be represented in whatever scenario is approved for undertaking the Prioritization Process.

San Francisco Redevelopment Agency
Summary Of HOPWA Activities and Balances
San Francisco Only
As of February 1, 2001

HOPWA Projects (by Type):				
Contracts In-Progress or Completed: (1)				
Capital Projects		$27,522,939		
Supportive Services & Operating		$18,719,263		
Rental Assistance		$13,790,461		
Technical Assistance		$861,558		
Program Administration		$1,978,400		
Sub-total		$62,872,621		
Proposed Projects:				
Capital Projects		$3,039,116		
Supportive Services & Operating		$0		
Rental Assistance		$0		
Technical Assistance		$35,000		
Sub-total		$3,074,116		
Grand Total (2)		$65,946,737		
Notes:				
(1) Includes all contracts/projects approved by the SFRA Commission as of 2/1/01.				
(2) Grand Total does not include the $1,370,000 HOPWA SPNS (Special Project of National Significance) awarded to San Francisco in 2000.				
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San Francisco Redevelopment Agency
Summary of HOPWA Activities and Balances
(San Francisco only)

Capital Projects:							
Sponsor	Location	Housing Type	Res. Population	Units/Beds #	Type	Cost per Unit/Bed (000's)	Dollar Amount
Operational Projects:							
Baker Places	1761-65 Page St.	Indep. Lvng.	Singles	16	beds	$44.0	$704,147
Baker Places	1249 Scott Street	Indep. Lvng.	Singles	12	beds	$39.6	$475,000
Bernal Heights	119-121 Holly Park	Indep. Lvng.	Singles	6	beds	$77.5	$464,786
Bernal Heights	416 Precita	Indep. Lvng.	Singles	6	beds	$76.5	$459,267
Bernal Heights	3554-17th St.	Indep. Lvng.	Families	9	units	$134.8	$1,213,590
BCA (Brandi Moore)	1761 Turk	Transitional	Singles	11	beds	$113.6	$1,250,000
CATS	1049 Howard	Licensed-SA	Singles	10	beds	$60.0	$600,000
Dolores St. (Richard Cohen)	220 Dolores	RCF-CI	Singles	10	beds	$37.2	$372,478
GLIDE Foundation	333 Taylor	Indep. Lvng.	Families	13	units	$84.6	$1,100,000
Larkin Street Youth Center	129 Hyde Street	RCF-CI	Singles	12	beds	$145.8	$1,749,937
Maitri	401 Duboce St.	RCF-CI	Singles	14	beds	$177.4	$2,483,626
Mercy Housing CA	141 Leland Avenue	RCF-CI	Singles	45	beds	$69.6	$3,131,240
MHDC (Apollo Hotel)	418-422 Valencia	Indep. Lvng.	Singles	8	units	$60.0	$480,000
MHDC (Juan Piffare)	1010 S. Van Ness	Indep. Lvng.	Families	10	units	$100.0	$1,000,000
Peter Claver Community	1340 Golden Gate	RCF-CI	Singles	32	beds	$14.1	$450,937
Walden (work-in-prog)	154 Coleridge	Indep. Lvng.	Singles	14	beds	$65.5	$917,600
Total - Operational Projects				228		$73.9	$16,852,608
Pre-development / Under Construction:							
Baker Places-214 Dolores	TBD		Singles	8	units	$141.2	$1,129,720
Bernal Heights-1652 Eddy St.	Late 2001	Indep. Lvng.	Families	7	units	$152.9	$1,070,119
Bridge - 1 Church St.	Late 2001 (93 total)	Perm Family	Families	12	units	$166.7	$2,000,000
Episcopal -165 8th St.	Late 2001 (48 total)	Perm Family	Families	5	units	$137.9	$689,407
Mission Bay - Orlando Cepada	TBD	Perm Family	Families	10	units	$100.0	$1,000,000
SFHDC - 4417-4445 3rd St.	Early 2002 (30 total)	Perm Family	Families	8	units	$150.0	$1,200,000
TNDC (Ambassador) -55 Mason	2004 (147 total)	Indep. Lvng.	Singles	23	units	$87.0	$2,000,000
TNDC - 864 Ellis St.	Mid 2001 (25 total)	Permanent	Singles	6	units	$105.2	$631,085
TNDC -1166-1188 Howard St	TBD (88 studios)	Indep. Lvng.	Singles	10	units	$95.0	$950,000
Total - Projects Under Development				89			$10,670,331
Total - Capital Projects				317			$27,522,939

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J. Chinn 2/7/2001

San Francisco Redevelopment Agency
Summary of HOPWA Activities and Balances
(San Francisco only)

Supportive Services and Operating Contracts:

Sponsor	Location	Type	Term	# of Units/ Beds	Dollar Amount
Contracts In-Progress:					
Cath. Charities (Housing Adv.)	Scattered Sites	Ind.Lvg/Hsng Adv.	7/1/00-6/30/01	325	$300,000
Cath. Charities (Leland House)	141 Leland Avenue	RCF-CI	7/1/00-6/30/01	45	$1,387,487
Cath. Charities (Peter Claver)	1340 Golden Gate	RCF-CI	7/1/00-6/30/01	32	$672,463
Dolores Street Comm. Svcs.	220 Dolores	RCF-CI	7/1/00-6/30/01	10	$462,804
Larkin Street	129 Hyde Street	RCF-CI	7/1/00-6/30/01	12	$331,833
Maitri	401 Duboce St.	RCF-CI	7/1/00-6/30/01	14	$464,642
Subtotal				438	$3,619,229
Contracts Completed:					
Baker Places - Ferguson	1249 Scott Street	Indep. Lvng.	3 years	12	$94,500
Baker Places - Rental Subs	Scattered Sites	Rental Subs	3 years	16	$157,613
Black Coalition on AIDS	BHCC Sites	Indep. Lvng.	3 years	12	$180,792
Cath. Charities (Housing Adv.)	Scattered Sites	(Listed above)	6+ years	--	$1,546,643
Cath. Charities (Leland House)	141 Leland Avenue	(Listed above)	3.5 years	--	$4,858,834
Cath. Charities (Peter Claver)	1340 Golden Gate	(Listed above)	5+ years	--	$2,800,777
Dolores Street Comm. Svcs.	220 Dolores	(Listed above)	5+ years	--	$1,800,776
Larkin Street Youth	129 Hyde Street	(Listed above)	3 years	--	$884,732
Lutheran Social Services	Ambassador Hotel	Rental Subs	3 years	15	$141,776
LSS - Hazel Betsey	3554-17th Street	Indep. Lvng.	1+ years	9	$143,804
Maitri	401 Duboce St.	(Listed above)	3+ years	--	$1,205,362
Mercy (operating contract)	141 Leland Avenue	RCF-CI	3 years	--	$476,419
Native American AIDS Project	Scattered Sites	Rental Subs	2 years	10	$51,100
SF AIDS Foundation	Scattered Sites	Rental Subs	3 years	107	$554,887
Walden House	154 Coleridge	Indep. Lvng.	3 years	14	$202,019
Subtotal				195	$15,100,034
Total - Supportive Services & Operating				633	$18,719,263

Rental Assistance:

				Maximum # of Units	
Contracts In-Progress:					
Partial Rent Subsidies	Catholic Charities	Scattered Sites	7/1/00-6/30/01	125	$547,394
Tenant Based Rent Subsidies	SF Housing Authority	Scattered Sites	7/1/00-6/30/01	325	$2,986,955
Subtotal					$3,534,349
Contracts Completed:					
Partial Rent Subsidies	Catholic Charities	Scattered Sites	1+ years		$725,085
Tenant Based Rent Subsidies	SF Housing Authority	Scattered Sites	6+ years		$9,531,027
Subtotal					$10,256,112
Total - Rental Assistance					$13,790,461

J. Chinn 2/7/2001

HOPWA CAPITAL PROJECTS

PENDING OR UNDER CONSTRUCTION

Pre-development or Under Construction (9)

SPONSOR	LOCATION	HOUSING TYPE	RESIDENT POPULATION	UNITS/ HOPWA	UNITS/ TOTAL	AMOUNT	PROJECTED COMPLETION DATE	SFRA STAFF
Bernal Heights Neighborhood Center (Positive MATCH Program)	1652 Eddy St.	Indep. Living	Families	7	7	$1,070,119	Late 2001	PS
Bridge Housing	1 Church St.	Permanent Family	Families	12	93	$2,000,000	Late 2001	MS/ LB
Episcopal Community Services	165 8th St.	Permanent Family	Families	5	48	$689,407	Late 2001	AK
SF Housing Development Corp. (North Gateway Apartments)	4417-4445 3rd St.	Permanent Family	Families	8	30	$1,200,000	Early 2002	PS
Tenderloin Neighborhood Development Corporation (Ambassador Hotel)	55 Mason St.	Indep. Living	Singles	23	147	$2,000,000	Late 2001	PS
Tenderloin Neighborhood Development Corporation	864 Ellis St.	Permanent	Singles	6	25	$631,085	Mid 2001	PS
Baker Places.	214 Dolores St	Indep. Living	Singles	8	8	$1,129,720	Early 2002	AK
Howard Street Development Corporation (subsidiary of TNDC)	1166 Howard Sts.	Indep. Living	Singles/ Families	10 singles	161	$950,000	Early 2002	VD
Mission Housing Development Corp.	Mission Bay/ Orlando Cepeda Place	Indep. Living	Families/ Singles	10	100	$1,000,000	Late 2001	MS
TOTALS				**89**	**619**	**$10,670,331**		

Rehabilitation of Existing Projects (5)

(Pre-development or Under Construction)

SPONSOR	LOCATION	AMOUNT	PROJECTED COMPLETION DATE	SFRA STAFF
Mercy Charities (Leland House)	141 Leland Ave.	$68,044	Mid 2000	PS
Bernal Heights Neighborhood Center (Hazel Betsy House)	3554 17th St.	$66,515	Mid 2001	PS
Bernal Heights Neighborhood Center (Precita House)	416 Precita, A & B	$74,917	Mid 2001	PS
Bernal Heights Neighborhood Center (Stinson House)	119 & 121 Holly Park Circle	$60,261	Mid 2001	PS
Walden House (Coleridge)	154 Coleridge	$257,735	Mid 2001	AK
TOTAL		**$527,472**		

Please note there are several projects that have not yet received San Francisco Redevelopment Agency Commission approval or Citywide Affordable Housing/HOPWA Loan Committee approval. As these projects become more viable staff will modify this sheet and report back on the status.

Revised 2/7/01

HIV Health Services Planning Council
Implementation and Evaluation Committee

February Report

Meeting Date/Time: Monday, February 5, 2001, 5:00 – 7:00 PM

Members Present: Sign-In Sheet not available at time of mailing

Others Present: Sign-In Sheet not available at time of mailing

Next Meeting: Monday, March 5, 2001 25 Van Ness, Room 330-B, 5:00 PM – 7:00 PM

Susan Shea Co Chair of the I & E committee opened the meeting at 5:00 PM. The meeting started with introductions and review of the Agenda. After the review, Susan asked for any additions to the agenda. There were none. Susan explained that last month's meeting had tabled the Hold Harmless until further information about the Budget from Re-Authorization. Laura Thomas said that the budget is being worked on but could not say when it would be announced.

Susan said that the I& E Co Chairs had a meeting with the Co Chairs of the Planning Council, Laura Thomas, Michelle Long Dixon of the AIDS Office and Jim Illig of the HIV Service Providers Network. Some of the ideas from that conference were shared. She said that after reviewing facts of last years prioritization and the fact the award may end up being about the same or maybe just a little more with the additional funds of the Congressional Black Caucus, that they should proceed in a different route from the last Prioritization. It was decided that this would not be the best way to proceed this year. She put forward a vision of this year's Prioritization having several goals in mind:

1. Educate the Council about the care system, as it presently exists (not just the part of the care system that is paid for by Ryan White CARE Act funds). The plan would be to have presentations by providers from different sub categories in order to inform the council how they provide care and where they get their funds, and what are the gaps in care especially as it relates to severe needs populations. This will benefit those members who are new to the council who do not know the overall care system, to understand better, what it is that the CARE dollars are supposed to be doing.
2. Examine what it is the council needs in terms of data to determine where the CARE dollars should be directed. This process should be done in concert with the people named earlier in the special committee. This would avoid a practice that has happened in the past where the Council would ask the AIDS Office for a multitude of different bits of information and never really use it. Or, have people make decisions based on information they did not understand. The data would be comprehensive and chosen carefully. It was suggested that the Council use private consultants or members of The Department of Public Health, or people from the University Policy Centers to come in and explain how to use data to make decisions regarding shifting dollars if that is the goal.
3. To select one or two goals or outcomes. This should not be a laundry list of a million things the Council would want to do, but maybe one or two overarching goals. An example given was to shift more money into the integrated service models. Or, should we examine populations: Who has the most severe need and what kind of programs and funding are going for those populations right now.
4. The next step would be to have the Co Chairs call a meeting to invite folks: Consumers, Planning Council Members which would include I& E, other Committees, the AIDS Office and Providers to have the perspectives needed. Then to turn half the Planning Council meetings into Educational

and Prioritization Forums to avoid burdening the council with additional meetings. To use the I&E time from 5-7 for some of this business. Those details have not been worked out, so the logistics still need to be worked out.

One issue that was brought up was new ways to get PWA involvement. Susan suggested that the Council needs to go to Forums, Support Groups, and Tenant Association meetings where PWAs meet on regular basis and bring some tentative ideas. The PWA Caucus would provide leadership in identifying these groups to guarantee that input from the PWA community.

A moment was taken to thank Laura Thomas for all her good work in getting the grant application in such good shape for us. Susan also said that it is important to stay on schedule and produce proper documentation in order for Laura to produce strong applications.

It was mentioned that another issue is to make sure adequate resources are available to do the groups and meetings, the minutes, and the outreach efforts in the Planning Council Support Budget.

Susan asked that the Prioritization Task Force or Organizing Comm. should consider these questions:

1. How much of this can we do with the Planning Council Support as it stands right now?
2. How much Consultant Support do we need and where can we get that. There are several people at UC Berkeley, UCSF and some of the Policy Centers. She said there are probably a few people around the area that would probably donate time.
3. The council may have to pay for some support, but we must decide what part can the Council do on its own with the help of the AIDS Office and the Department of Public Health, and what part do we need help in facilitation. This would mean sitting down and looking at the whole process from start to finish and determining what parts we would need help and what we would not need help with.

A request was made to get a history of what has worked in the past, and what was the cost of the outside help. The Support Center had facilitated Annual Retreats and one year they facilitated focus groups. They also facilitated all day Saturday retreats where the council finalized Prioritization. This was helpful because it allowed for everyone on the Council, including Co Chairs and Chairs of Committees, to step out of their roles and participate more freely.

Susan brought up the fact that there had been some controversy regarding how good a use of our Council Support Budget it is to pay for facilitation work. Prioritization is supposed to be our job. Laura Thomas suggested that the council should examine the process, review the needs, and then look into the Council to see who can provide the skills needed. Then go from there to consider what outside support to pursue: either volunteer or contracted support. Facilitators do help move the process along. It enables all Council members to participate on equal footing. Then when Council members have to guide the process.

Another member stated, having outside facilitators, brought a certain level of objectivity to the process.

Susan asked the committee how they felt about the idea of trying to whittle down the overall work of the Prioritization to eliminate the "Wish List". Where do we want to be at the end of the process? Susan also said that one of our main objectives should be to focus on a smaller amount of directives than we have in the past. Also, remember last year we just reviewed the prioritizations for the prior year and that lead to a nightmare when the budget issue came up and we almost had to do a mini-prioritization.

Another member lead the discussion regarding the end-product and suggested that she would like to be able to identify those services that are most utilized, and most needed for people with HIV. She clarified utilized as those services that are really used. *Steve Oxendine* agreed and pointed out that some utilization data can be obtained and see if the data squares with what folks say the needs are.

Susan brought up the fact that one must look at the fact the most severe need clients may be the most under-utilized population like those living under bridges, their utilization is zero. The more utilized services will be obtained by ones that have Medi-Cal or other insurance. It is important to look at the data carefully and ensure that the severe need population is looked at, because they are the ones not using the services.

It is important for the council to understand what it means to be Out of Care, fixed income, outside of CARE funded services. There is a big difference, from the provider stand point, we see your funding as core funding for HIV and there is other funding that also takes care of people with HIV and you don't know about them because you don't consider them when making Prioritization. So we should take a year to educate the council on what the service system looks like right now.

Plan: Set up a series of presentations by providers about the "Care System" and then talk about what the CARE dollars do within that care system and try to figure out if the dollars are targeted to the most severe need and the people we really want to use for wrap-around services. This process would be the first part of prioritization. At some point, people are going to want to know some of the data but not tons of data. When this data is presented it must be presented in a fashion and with explanations that make sense for the entire council. This is the first step.

Steven Oxendine stated that a shift in the way we look at CARE dollars is of paramount of importance as we plan for the future.

Laura Thomas talked about the requirements the Council is mandated to look at in terms of the Priority Setting Activity. She listed examples such as listing services in order, set the allocation of dollars for each category and develop a comprehensive plan. There is also a list of things to take into account such as:

Demographics of the epidemic
Priority of the community
Priority of consumers
An assessment of Gaps in Services

This year a new issue is being looked at around people who know their status and are not in care and developing programs to reach them. There is a very fat list that the council needs to take into account as well as a fat list of out comes they need to have at the end of the process. You can look at the two-year process in a number of different ways in that you are going to tackle something this year instead having something to tackle next year. Or you can look plan for this year and next year is just a review.
Laura Thomas added, that the council will also have the first section of the long-range plan done by the March meeting and the long-range plan committee is working on this. The section that will be done are the description of the epidemic and the service system and the shared value, shared vision but not the goals and objectives of the priority setting.

Susan explained that the prioritization is so labor intensive and suggested the committee to get volunteers to track a few of these things with the AIDS Office to assure that they are on schedule. Also, come up with some suggestions on how to keep track of all of these other projects that are happening parallel with Prioritization Activity. The AIDS Office will give us up dates on the progress of the Long Range Planning and the Standards of Care. We will also need to hear from the AIDS Office about what will be going on with these projects during the Prioritization period. Steve Oxendine suggested to split personnel. Susan is concerned that there might not be the person power to do both projects with good representation.

Planning Council Satisfaction Survey

As part of the annual evaluation process for the Planning Council's administrative support services, we are requesting feedback about your experience. Would you please complete this survey evaluating the Council's administrative support services and tell us what we might do to better serve Council members?

Your reply will be anonymous unless you wish to identify yourself. For each of the following items, please check the box that most closely describes your satisfaction with your experience.

	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
1. How satisfied are you overall with the Council's administrative support services?	☐	☐	☐	☐	☐
2. How satisfied are you with the timeliness of receiving the monthly meeting packet?	☐	☐	☐	☐	☐
3. How satisfied are you with the thoroughness and accuracy of meeting minutes?	☐	☐	☐	☐	☐
4. How satisfied are you with meeting logistics support (meeting room, food, etc.)?	☐	☐	☐	☐	☐
5. How satisfied are you with the responsiveness of administrative support staff to requests?	☐	☐	☐	☐	☐

Are you a: Council Co-Chair? Yes ☐ No ☐

Committee Co-Chair? Yes ☐ No ☐

If you answered yes to either of the above questions, have you received the administrative support you requested and/or needed? Please explain as appropriate.

Gender:_____ Ethnicity:_____ Sexual Orientation:_____

Consumer Representative?_____ Service Provider Representative?_____

Please share below your comments, suggestions or advice. We are particularly interested in feedback on those aspects of your experience where you were not satisfied with the administrative support that was provided. Please feel free to use additional paper for your comments and suggestions.

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Minutes, February 26, 2001 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at its next meeting

I. Call to Order
4:44 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda had revisions, and was then adopted by consensus.

IV. Review and Approval of Minutes, 01/22/2001 – Action taken
01/22/2001 Council Meeting Minutes – No changes or corrections were requested. It was moved and seconded to approve the draft of these minutes; the motion was passed by a unanimous vote with two abstentions.

V. General Announcements
Laura C. Guzman announced her term is up at the end of March and she has decided not to reapply for another term. Therefore, she will be resigning as the Co-Chair of the Council.

Brad Hume announced that on Wednesday February 28, 2001 the Department of Public Health and the Ark of Refuge would be having an Open House. This is a Transitional Living Program for Homeless Lesbian, Gay, Bisexual, Queer and Questioning Young Adults. The address is 2500 Market Street at Castro and 17th Street.

VI. Public Comment
Jim Illig with Project Open Hand spoke; he is the President of the HIV/AIDS Provider Network, which is the association of contractors. They meet the first Friday of every month. He announced that everyone was invited; it is a public meeting. He said that at their last meeting, Laura Thomas' announcement from the prior council meeting was brought to his attention. Representative Pelosi got $1.1 million for HIV Services at San Francisco General. This does not come through the council; it goes directly to San Francisco General from the Federal Government. His concern is to see that the money goes toward enhancing and expanding the services. The Appropriations language specifically says it is for women and People of Color. A Task Force has been formed to decide where this money goes. He asked that the Council join in efforts of the HIV/AIDS Provider Network to assure that this money is not being consumed into the deficit, and to assure that the money goes to something new for women and People of Color at San Francisco General. The second thing he wanted to let the council know is that the fiscal year ends on Wednesday February 28, 2001, and the new fiscal year starts Thursday March 1,2001. None of the providers have received any indications from the AIDS Office about renewed contracts. Unlike previous years, there have been no notices. Providers are expected to continue providing services on Thursday even though the money stops and as yet no documents have started the process of the City system. The department did ask for a four-month extension for all contracts, but the providers would have to apply for that extension.

VII. Reports
SF Department of Health presentation was canceled until next month; representatives were in Washington at a HRSA conference.

VIII. Responding to Racial and Ethnic Disparities in HIV Care (Part 2)
Laura C. Guzman presented. Assisting were representatives of Clinica Esperanza, which is part of the Mission Neighborhood Health Center. Silvia Moreno and Carlos Morales reported on some of the issues that immigrants face when trying to apply for HIV services. The presentation covered issues concerning barriers faced by immigrants and the complications they face with an HIV or AIDS diagnosis. Some important information was shared:

- Even though an immigrant may come to the United States and receive Refugee status or asylum for reasons associated with political involvement or sexual orientation, they are not eligible for SSI.

- HIV is considered a communicable disease, and the INS can deport an immigrant even if he or she is a legal resident or holder of a green card.
- Persons with HIV may be denied entrance at the point entry or immediately deported.
- Confidentiality is a very important concern of immigrants. There is always a concern regarding records and information obtained during medical exams and when applying for social or financial assistance. These issues are direct barriers that keep immigrants out of care.
- Many immigrants are identified by the INS as "Prucol," which refers to people in many different situations who are granted temporary permission to stay in the U.S. This status can last as long as 20 years. This acronym means 'people residing under color of law.'
- Immigrants can only receive Emergency Medical treatment using Medi-Cal. Many Latinos are relying on ADAP rather than Medi-Cal. California has decided that qualified applicants and Prucal may tap into Medi-Cal. Most people do not know this, and may believe that getting on Medi-Cal can get you into trouble when applying for an HIV waiver.
- Renal dialysis is the one type of care that immigrants may receive using Emergency Medi-Cal, even though this may be on-going care for the rest of that person's life.

ADAP qualifications are not as strict as Medi-Cal. All immigrants qualify for ADAP, but because of the stigma many people do not apply for ADAP. She also pointed out that individual immigrants have been forced into applying for Medi-Cal when they could have applied for insurance through their work. People have been scared into applying for Medi-Cal even though these people may have already gotten their green card. Laura passed around information regarding The Immigrant HIV Assistance Project, which is funded by CARE dollars and have worked wonders in the lives of people who have been able to qualify for political asylum due to sexual orientation. Laura recommended that the Council continue to look at the needs of immigrants who have unique concerns that do not reflect other populations.

CLINICA ESPERANZA

Carlos Morales shared information about the services provided at the Mission Neighborhood Health Center and focused on how Clinica Esperanza works with immigrants, including how it handles questions and issues about access to medical treatment. He also talked about how they help clients take a more proactive stance regarding their immigration status. Clinica Esperanza has been working with HIV-positive folks for over ten years now. The Clinic has an Early Intervention Program, which combines both the medical and psychosocial components. The focus is on treatment and prevention, providing medical services and psychosocial services such as referrals and case management. This covers entitlements, housing and benefits counseling through Positive Resource Center. One of the major concerns to the client seems to be "Since I am here in the U.S., how is this going to affect my immigration status?" They work at building trust with the client so that they can get a full picture of what is going on in all aspects of their lives. Many clients are afraid to divulge information because they are leery of what could happen later. Concerns can even arise from the fact that the client's name is on certain forms; they would want to know where that information is going. The Clinic tries to deal with concerns by informing clients that nothing is going to be sent to the INS or to anyone else without the permission of the client. The clinic tries to work with the client's family because immigrants have a host of different concerns related to their families, particularly how to keep the family together. Language barriers are a big concern and most of the providers are Bicultural and Bilingual (Spanish). Of course they also serve other immigrants, such as Asians and Brazilians. In addition, the Clinic has seen a steady flow of women clients.

Health Education is an important factor because when a person sees a lawyer regarding asylum, the lawyer is going to try to circumvent the HIV issue. It's important that clients connect to available prevention programs that provide health education and information, which helps them become aware of how communicable this disease is. The Clinic also provides massage therapy and acupuncture as well as psychiatric care. This has a lot of value if the client shows evidence of dealing with high levels of stress during the asylum process. Sylvia Moreno pointed out that mental health support has proven to be essential for the person going through the asylum process, which can at times be very depressing and very stressful. Thus far there have been 40 political asylum cases. There is evidence that several of the clients have experienced sexual abuse, perhaps from family or neighbors but also by the police. Many of these people never shared this information until they started therapy at the clinic. Carlos pointed out that there is a language barrier that delays attempts to obtain political asylum but that many clients can get assistance with their applications. The law requires that a person apply for political asylum within the first year after entry

into the United States. Clients that have not done this usually feel that they are too late after the one-year period. So, an assessment is made on the client before contacting a lawyer. When the client is ready and can handle the stressful process of political asylum, referrals are made to start the process. To handle emotional turmoil, they refer clients for individual counseling.

Laura said that this information was presented in order to show how the immigration laws affect the trends showing ADAP is the one funding source that is relied upon by Latinos, despite the restrictions with it. Care is limited for these specific individuals because they are only able to access parts of the medical system. She wanted the Council to also be aware of the other services needed to survive, which are not being addressed. It is important to know that the INS presents many barriers, with sexual preference and HIV sero-positivity being two issues that can lead to deportation. She encouraged every agency to use the services in order to help their clients deal with immigration as well as HIV disease.

IX. Tenderloin Community Forum

Gary Harrell reported that the Forum was a success and wanted to thank participants for their hard work. He said there was a high turnout and a couple of clients brought in pictures and posters to share with us about the conditions they were living with in their housing. The Forum was an opportunity for consumers to speak about the obstacles they have accessing services or dealing with unfamiliar protocols for treatment. *Cecilia Chung* felt there should be some appropriate follow-through to this Forum. She pointed out that one of the major concerns was housing (SRO). She wanted to know what is the council going to do with the information received from the Forum. *Steve Oxendine* said he agreed that we should set a plan in action but suggested greater care in the language used. The Council cannot go beyond its appropriate role in addressing the concerns of clients about their housing situations, particularly SRO conditions. *Fernando Gomez-Benitez* pointed out that the Housing Committee had discussed these issues any number of times. Still, the conditions of SRO housing are getting worse all the time. We should find a way to force City agencies to get together and find solutions for this population. He proposed that the PWA Caucus start looking into advocacy with the new Board of Supervisors and organizing constituents. He suggested that if the Council could get advocates and constituents alike to bring attention to this matter, the Board of Supervisors as a whole would have to take action to make some changes.

A strong conversation erupted around how this course of action could be pursued. *Steve Oxendine* suggested that this discussion should be addressed in committee work. *Brad Hume* encouraged people that are concerned about the housing situation to come to the next Housing Committee meeting where time could be utilized to set a course of action in motion before coming back to the Council.

BREAK

X. Consumer Rights Advocacy Project

Jim Mitulski gave a brief history of the HIV Consumer Rights Advocacy Project and explained that Richard Bargetto has been doing an excellent job but would be taking a three-month sabbatical. He wanted to recognize Richard's efforts. Richard then gave a report on the trends he has found with his clients in the last year.

Richard explained how he has been involved with Clients. The range was from "pre-grievers" to individuals who went through the whole process and were not happy with the outcomes of their grievances. Richard explained that he intervenes at all points in the process. He noted that there did not seem to be a trend as to whether he might see more cases at one time of the year or another. One note was that there was less participation in his services by African Americans and females. Richard noted that once he returned from Italy he would do more outreach to try to get higher levels of participation from these groups. He also did a breakdown on the types of services, which may affect the Council's decisions in its priority-setting process, based on the trends in grievances. Number one was housing, Susan Shea asked if the issues around Housing were related to quality or availability of housing. Richard responded that the issues seemed to deal with both availability and quality. He has worked with a lot of Derek Silva clients (since it is so close, residents came by frequently). Some clients have complicated issues because of dual diagnosis. In residential settings, when one client is unhappy their issues tend to grow and spill over, making other clients unhappy as well. Another Service Category that had a high number of grievances was Case Management. *LCG* had questions regarding the nature of these complaints. Richard explained that the grievances had to do with a desire to change Case Managers, while agency policy was not to permit such changes. These clients shared a history

of lack of trust ("maybe the client was given bad information and just did not trust that individual anymore or maybe the case manager and the client were just a bad match in the beginning.") Richard was asked about the rate of client satisfaction with the handling of their grievance. He has about a 70% satisfaction rate, but that meant 70% of the clients received feedback on whether their claim was legitimate or not. A question was asked about Richard's involvement with SROs. Richard said that he usually did not get involved with SROs because it was beyond his purview. However, on occasion he has written to SROs. He remembers that one case dealt with the policy on having guests. A letter was written in this case and the issue seemed to become a little more tolerable. A question was asked regarding the reaction of the agencies Richard has had to address with grievances. Richard said that most were responsive. One member, who works in housing, brought up a few problems that she recognized the Council has contributed to through its recommendations. For example, the council mandated that only clients with very low income, or homeless, and are triply diagnosed may be served. This is what the agencies follow and DPH puts that language in the housing contracts.

XI. PWA Caucus

The last meeting covered a plan for recruitment of new members that will meet the HRSA recommendation for non -affiliated consumer participation and get a balanced ratio. They discussed prioritization and long-range planning. It was mentioned that Laura Thomas will meet with the Caucus next month to go over the language from the Long Range Plan.

XII. I & E Committee

Susan Shea distributed a document about plans for the Prioritization process. This plan is coming from the I&E Committee for discussion by the Council as a whole. The first issue to discuss is how to start the activities. In the past years, the Council suspended all regularly scheduled activities in order to concentrate on Prioritization. She went through some past history about setting up work groups or task forces to tackle different areas of focus, such as housing, primary care and so on. The chairs of these groups would set a schedule for meetings and get input from providers, consumers, and Council members. Susan explained that in the last two or three Prioritization processes in which she participated, the Council came up with a wish list of top projects on which to try accomplishing specific actions. Last Prioritization, over 120 different projects were viewed as priorities. This "wish list" approach makes it difficult for the combined efforts of the AIDS Office, DPH-HHS, DPH-Housing Services and the I&E Committee to actually implement. The Council needs a new methodology. She shared some suggestions:

- Have an education phase in the prioritization process. Learn the process and what the goal should be in relation to the funding source (HRSA) and the grantee (the AIDS Office).
- Have comprehensive education about the Care System (CARE-funded, as well as other aspects of the care system in general).
- Provide the Council with substantial detail regarding who is being served and what money pays for that service.
- Have education regarding Conflict of Interest – What does conflict of interest really mean and how do we hold discussions? How do we monitor conflict of interest and what rules do we play by?

Then, the next part of the work would be goal setting: What are our goals and outcomes? What is the required data we need in order to set goals and how do we use the data to evaluate our goals. Also in this phase, we need to make sure that we have met with the difficult-to-reach and out of care population so we can hear more about their needs.

An organizing committee will meet to set the plan for the Council to accomplish its work on Priority Setting Activities. There was concern regarding AETC (AIDS Education Training Center) participation in the Prioritization Organizing Committee. Susan supported the participation by saying that a member of the AETC, Bob Teague, is a Council member and his input would be very valuable. After brief discussion, it was agreed that Bob would be invited to participate, but in more of a Consultant or Advisory role, especially focusing on the education aspects of the overall plan.

A question arose regarding the amount of participation to anticipate from Council members. *SS* responded that the participation would be the same amount of time that is currently required of members, since most of the work will take place during the already-scheduled meetings of the Council. The only difference is the work would be toward Prioritization.

No formal motion was needed to create the Prioritization Organizing Committee. *Susan Shea* said she wanted to move forward with its formation and would take into account the input provided in this preliminary discussion. She said she would be getting in touch with potential members for the Committee regarding a time and place for the first meeting.

XIII. Membership Committee – Action Taken

A list containing one re-appointment and three potential new members was passed around for consideration and a vote.

Discussion: *Greg Neumark* said he would vote no on this slate. He mentioned that he did not want his comments to be taken in the wrong way, but he feels that the best people to advance as nominees to the Council at this time would be persons who are HIV positive, or non-affiliated consumers of service, because they can best make recommendations on the service system. PWAs deal with these issues everyday and can be the best evaluators in a process of prioritization. Because of this, he believes that all new members voted on should be PWAs and he will vote that way from now on. *LCG* explained that Toni Butler, who works in STD treatment and services, was nominated because HRSA mandates that there be participation from entities that work in some capacity related to STDs. She would be replacing Jeff Klausner, and this would not be an additional seat taken away from any other membership category. Her nomination is a replacement for a current member, who is resigning pending Toni Butler's appointment to the Council. The Membership Committee is moving aggressively to reach the 33% minimum level of participation by non-affiliated consumers. The slate of people nominated in this meeting includes two members who are in the category of non-affiliated consumers. The question was called. Those nominees who were present introduced themselves. Motion to recommend the entire slate of nominees was approved by a vote of 18 for, 2 opposed, and 2 abstentions (see Roll Call Sheet, Column 2).

XIV. New Business

SS had a last minute request to discuss a letter of intent for an application under Title IV, which would provide funding to support women and children. A Proposal was sent around for the edification of the Council.

XV. Adjournment

Meeting was adjourned at 7:45pm.

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

February 26, 2008[1]		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P	Y								
2. Hazel Betsey	*HB*	P	Y								
3. Jeff Byers	*JB*										
4. Bart Casimir	*BC*										
5. Cecilia Chung	*CC*	P	Y								
6. Raymond Combs	*RC*										
7. John Conley	*JC*	P	B								
8. Mark Dunlop	*MD*										
9. Gregory Edwards	*GE*	P	Y								
10. Catherine Geanuracos	*CG*										
11. Fernando Gomez-Benitez	*FGB*	P	Y								
12. Gene Gowdey	*GG*										
13. Laura Carcagno Guzmán	*LCG*	P	Y								
14. Gary Harrell	*GH*	P	Y								
15. Brad Hume	*BH*	P	Y								
16. Sam Kaplan	*SK*	P	Y								
17. Jeffrey Klausner	*JK*										
18. Gene London	*GL*	P	Y								
19. Carmen Madríz	*CM*	P	Y								
20. Michael Meehan	*MM*										
21. Allen Meyer	*AM*	P									
22. Jim Mitulski	*JM*	P	Y								
23. Gregory Neumark	*GN*	P	N								
24. Stephan Oxendine	*SO*	P	Y								
25. Ken Pearce	*KP*	P	Y								
26. Alissa Riker	*AR*	P	Y								
27. Susan Shea	*SS*	P	Y								
28. Janis Takamoto	*JT*	P	Y								
29. Bob Teague	*BT*										
30. Robert Whitford	*RW*	P	N								
31. Mary Jane Wood	*MJW*	P	B								
32. Kelly Wallace		P	Y								

18-2-2

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

March 26, 2001 4:30 PM

AGENDA

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I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes, 2/26 — VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *SF Department of Public Health*	**4:55 PM**
	- CBC, Unfunds, and Contracts	
	• *Long Range Planning Discussion*	**5:10 PM**
	• *Bylaws Revision Discussion* — **VOTE**	**5:35 PM**
Break		
		6:00 PM
	• *Steering Committee*	**6:15 PM**
	- Prioritization Organizing Committee: Composition, Meetings & Process	
	- Co-Chair Nominations	
	• *PWA Caucus*	**6:35 PM**
	• *Implementation & Evaluation Committee*	**6:40 PM**
	- Reductions Protocol — **VOTE**	
	- Budget for FY01-02 — **VOTE**	
	• *Housing Committee*	**7:10 PM**
	• *Membership Committee*	**7:15 PM**
	- Nominees — **VOTE**	
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Mon	4/2		25 Van Ness, Room 330	5:30 – 7:00 PM
Wed	4/4	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	4/4	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	4/9	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	4/16		25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	4/19	Membership Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	4/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	4/30		25 Van Ness, Room 330	

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Meeting Reports from

Thursday, March 15, 2001 (Membership Comm.)

And

Monday, March 19, 2001 (I & E Comm.)

Have not been prepared by the mailing date, March 20th

They should be available as handouts at the Council meeting.

- Membership will be submitting three nominees: one a re-appointment, the other two new people.
- I and E is planning to present two motions to the Council.

Implementation and Evaluation Committee

March Report

Meeting Date/Time: Monday, March 5, 2001, 5:00 – 7:00 PM

Next Meeting: Monday, March 19, 2001 25 Van Ness, Room 330, 5:30 PM – 7:00 PM

Present: Susan Shea	Co-Chair of the I&E Committee
Michelle Long Dixon	Director of HIV Care at the AIDS Office
Laura Thomas	Health Planner, AIDS Office
John Conley	San Mateo Health Department – Planning Council Member
Mary Jane Wood	Planning Council Member
Kevin Johnson	Staff
Steve Feeback	Staff
Greg Edwards	Planning Council Member
Gene London	Planning Council Member
Bob Teague	Planning Council Member
Russ Zellers	HIV Health Services/AIDS Office
Jim Mitulski	Council Co-Chair
Nan O'Connor	Center for Special Problems
Tim Patriaria	Maitri
Bill Musick	Maitri
Celinda Cantu	DPH-HHS
George Simmons	CCASF
Chris Callandrillo	CCASF
Jim Illig	Project Open Hand
Bart Casimir	Planning Council Member
Steve Oxendine	Planning Council Co-Chair
Greg Neumark	Planning Council Member

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Review of Agenda
There was one change.

Notification of contracts for 2001
Russ Zellers presented the schedule for the FY 01-02 contract cycle covering CARE funds and General Fund connected to CARE. First cycle of award letters went out on 3/01/01. There will also be trainings offered. Contracts do begin on March 01, 2001 and the money is already accounted for. Award letters were sent out late by HRSA, and this is why there is a slow turnaround in getting notifications out to the contractors. Michelle Long Dixon explained that things are starting later this year because Appropriations were late and there was a change of administration. She also explained that not all contractors have cash flow problems, and the ones that are experiencing these problems are being addressed. These organizations can apply for extensions on their current contracts. The ones that have applied are being attended to.

Funding for 2001
Michelle shared a document called the CARE REDUCTIONS PROTOCOL (FY 2001-02). Overall, CARE Title I funding to the San Francisco EMA has declined steadily over the past six years. The document outlined a plan for addressing the gap between funds available in our FY01-02 award and the funds needed to maintain the current level of services. See chart below (figures are approximate).

FY 01-02 CARE Title I Award (minus 5% admin)	=	$33,983,069
FY 01-02 CARE Title I contractual amount	=	$34,408,024 (this is level funding)
FY 01-02 Deficit	=	$ 424,955

Michelle explained that the AIDS Office staff had worked hard at making the reductions as painless as possible. The planning was undertaken in order to make up for the 2% reduction in the CARE formula. Fortunately, the supplemental portion of our award was higher than anticipated and this more than made up for what was lost in the formula. HHS has sought out other sources of funding to complement and support the CARE-funded service system. These efforts were successful in the area of Program Support. The State Office of AIDS has agreed to adopt San

Francisco's current Treatment Education Certification Program (TECP) and expand it to become a statewide program. The receipt of a grant from the Office of Minority Health to provide technical assistance and capacity building to HIV service providers in communities of color allows a reduction to the current contract for technical assistance to providers while maintaining a consistent level of service for providers as a whole. Savings will be generated as follows:

Program Support	Savings
Technical Assistance	$ 50,000
Training and Education	$150,000
Subtotal	**$200,000**

Russ Zellers explained that the amount they need to cover is approx. $424,955 and the $200,000 that Michelle described reduces the deficit to roughly $224,000. Per the Reductions Protocol, most of this will come out of programs identified as not utilizing their contracted funds over multiple years. Providers have been notified in advance of these reductions. Savings is also generated by the closure of one case management program. The programs listed below (figures may have been subsequently revised) will generate some savings:

Outpatient Mental Health	$ 19,281
Outpatient Substance Abuse	$ 75,000
Primary Care	$ 12,650
Childcare	$ 15,000
Case Management	$ 65,126
Subtotal	**$187,057**

Michelle and Russ explained that these were negotiated reductions and the providers have agreed to these reductions. Michelle said that Mental Health, Substance Abuse and Primary Care are core services, but these cuts are in programs not meeting their contract targets or no longer in operation. The Childcare program had been under-utilized for the past three years, so these dollars were left unspent. The Case Management is a closed program. The savings of $187,057 would result in a remaining deficit of approximately $38,000.

A discussion about the second level of reductions took place. The issue was how this money can be shifted back into the same categories but offered to other agencies that are meeting their contract targets. It was explained that the amounts were so small and HHS would have to go through the process of an RFP in some cases (Request for Proposals). Perhaps, the $75,000 and the $65,126 would be amounts that could be considered for a RFP. Susan Shea recognized that many members may want to prevent this money being eliminated from Outpatient Substance Abuse and Case Management by putting it back into those Service Categories.

Michelle Long Dixon clarified that part of the decision-making process of the Committee is to decide whether the Council would want these dollars to continue doing the same thing for the same target population or should the money go back into that category and do something different. So, the Council would have to be specific in its recommendations to the AIDS Office. To help the Council, the AIDS Office can provide a profile of the programs. Laura Thomas reminded the committee that the rollover dollars are one-time money. Michelle also explained that the Carry Forward dollars are expected to decrease each year, given higher utility bills and no automatic cost of living increases. Therefore, it is expected that more contractors will spend all of their money. It is important to recognize that there is an inherent problem with deficit spending (using Carry Forward to make up for a shortfall).

Laura Thomas said that last week's meeting in Washington was extremely depressing. The allies of the fight against HIV/AIDS are not in power now. There is no leverage. This administration is determined to move forward with a tax cut. The next priorities are the military and education. The health care agenda would be to increase the NIH research budget.

John Conley spoke in favor of not using deficit budgeting right now. He suggested that if we find that we are getting out of balance by accepting these cuts, we should look at this later in the priority-setting process. Then it should be corrected the following year. He explained that San Mateo County does not do deficit budgeting. In the past, San Mateo did and he is aware of the results. When it catches up to you, it can be devastating. It is not services like the ones here that are not being utilized, which end up being cut. Services that are being utilized also get cut. Staff positions get eliminated. It can happen quickly and there is no way to change it. If no one is using the services right

now, then there is really no loss. Cutting these services is actually something that strengthens the others by not threatening them in future cuts. *Gene London* stated that as a provider he appreciated Johns' comments but also wanted to express his concerns about losing funding. He pointed to cuts that had taken place to poorly performing programs within the service category he is most familiar with – complementary therapies. No money was ever put restored to that service category once the cuts in some programs had taken place. He sought clarification of this process. *JC* responded that it is important to go back and revisit decisions of the past to re-assess if money should be re-distributed between categories or within a category. This process should happen during Prioritization and not at this time.

SS said she would provide information regarding past protocols and votes taken with regard to Unfunds and core-versus-non-core services.

Congressional Black Caucus Award
Michelle Long Dixon explained that there have been some changes in the Minority AIDS Initiative. The Planning Council requested last August that the AIDS Office look at categories carefully, in the advent that there is additional funding, to assure that those dollars include Peer and Treatment Advocates in the minority communities. In review, they noticed that some organizations have trouble retaining qualified people in those positions. A recommendation was made not to put more money into this category due to the difficulty of hiring staff and obtaining units of service.

HRSA has continued to clarify certain regulations, one being that the award is intended for minority providers. The definition, by CDC definition, is at least 50% of the Board being people of color and at least 50% of the population served also people of color. The funds are available to provide capacity building for minority organizations, so they can provide services in their own communities. In San Francisco the conversation should revolve around how best to use the dollars for capacity building to enable providers in the future to provide services in their own communities.

Presently, San Francisco is funding five programs with CBC dollars. With the new regulations two of the currently funded programs do not fit the definition of minority organizations. HRSA says it does not matter what has been done in the past; if organizations are no longer in compliance, they can no longer get the funding. So there has been a decision to put the full amount of CBC funding out to bid this year. The focus will be on unmet needs and finding people who are out of care; then developing programs to identify those individuals, encourage them into care, and provide support to keep them in care. In addition, it would allow applicant organizations to propose what they believe is needed in their own communities. A report will be submitted to HRSA to explain this plan.

Providers that are not in compliance after this change of regulations will have a contract extension until an RFP is developed and new providers are identified. Minority providers in San Mateo will also have an opportunity to respond to the RFP. The total amount this year is $472,779, which includes an additional $116,601 added this year. The RFP will be a little different this time. It will ask questions about the unmet needs of the communities. This will allow an opportunity for organizations that are not presently care providers, but would like to provide HIV related care, to get the capacity and be eligible to apply. This is still very new to the AIDS Office and HRSA has not provided much written guidance.

Carry Forward Dollars
When the Carry Forward dollars are identified, the AIDS Office needs clarification from the Council on the allocation of this money. *SS* said that the Council would not know the amount until June or July. Michelle clarified that although the Council will not know the amount, it should nonetheless have an idea of where it wants to allocate this money. Susan asked if this matter could be rolled into Prioritization 2002. She said there would not be a forum to discuss Carry Forward dollars until June. Susan also said she would research the notes from prior unfunds discussions because the committee has already provided some guidance.

New Business
Susan Shea said that there have been a number of complaints regarding the meeting time of this committee. For those who work it is just too early, and when they arrive, the meeting is already in session and they cannot catch up. It was suggested and agreed to start at 5:30 and end at 7:00. Susan announced that unless there were objections to her representing the I&E Committee on the Prioritization Organizing Committee she would be that representative. However, it is expected that many members of the I&E committee will be working with this committee once everyone knows what they are doing.

The meeting was adjourned at 6:55 PM.

HIV Health Services Planning Council
Steering Committee

March Report

Meeting Date:	Monday, March 12, 2001, 5:00 – 7:00 PM
Members Present:	Jim Mitulski, Council Co-Chair; Laura Carcagno Guzman, Council Co-Chair; Brad Hume, Housing Comm. Co-Chair; and Susan Shea, I&E Comm. Co-Chair.
Others Present:	Michelle Long Dixon, Laura Thomas and Russ Zellers, DPH, plus Steve Feeback, minutes
Next Meeting:	Monday, April 9, 2001 25 Van Ness, 5th Floor Conf. Room, 5:00 – 7:00 PM

Call to Order

Bylaws Revisions
Several proposed changes were submitted in written form to Council members at the past Planning Council meeting. The intent was to give sufficient time for members to consider the proposed language. A vote on those changes may be held at the upcoming meeting. Amendments may be offered by the membership.

Long Range Plan
Laura Thomas attended the last PWA Caucus meeting and held additional small meetings with other members. The document is ready to present and discuss further.

Presentations for 3/26 Council Meeting
It was decided to limit the reports to SFDPH HIV Health Services, the Long Range Planning Document and the Bylaws Revisions. Each may take some time, so no other topics were scheduled for presentation.

IEC Report
Susan Shea proposed that the I&E Committee schedule a vote/discussion on a Recommendation Related to Current Funding Issues. They will also reference Fall Unfunds and present information about the FY01-02 budget.

Steering Committee Report
Susan Shea recommended that the Steering Committee report to the members about the Prioritization Organizing Committee: its composition, meeting schedule and process. Additionally, it was decided that the Steering Committee would issue a call for Council Co-Chair nominations, thereby initiating a process to replace *Laura Carcagno Guzman,* whose resignation is effective at the end of March.

Adjournment
Jim Mitulski adjourned the meeting.

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March Report - PWA Caucus Meeting

Meeting Date:	March 7, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:00 PM
Members Present:	Bart Casimir, Cecilia Chung (Co-Chair), Ray Combs, Gary Harrell (Co-Chair), Brad Hume, Jim Mitulski, Greg Neumark, and Robert Whitford.
Others Present:	Richard Bargetto, HIV Consumer Rights Advocacy Project; Steven Feeback, minutes; Kenny Landes, Council nominee; Carolin Laufer, Observer; John McLaughlin, guest; Wayne Peace, Council nominee, and John Rosenzweig, Acting HIV Consumer Rights Advocate.
Next Meeting:	Wednesday, April 4, 2001, 25 Van Ness, Room 330-B, 5:30-7:00 PM

Welcome and Introductions

Members introduced themselves and added some items to the meeting agenda.

Report from the Consumer Rights Advocacy Project

Richard Bargetto provided his report covering the month of February 2001 *(see attachments)* and introduced John Rosenzweig, his temporary replacement during the period of his Leave of Absence. All remains the same with this project and its services during the three months that Richard will be gone. Richard ran through the new cases from February. He highlighted a case in which clients lost their housing subsidy provided through SFAF for reasons related to domestic violence. This case was resolved because the Advocacy Project made inquiries with the Foundation. The couple wanted to stay together and is doing so under Court order to undergo counseling. So SFAF agreed to hold off on any termination of the subsidy. Another housing case involved a client's eviction from Derek Silva for reasons related to throwing a chair at another resident. This case also got resolved because Derek Silva agreed to withdraw the eviction papers and require anger management classes instead. Another eviction at Derek Silva could not be resolved so successfully. The Advocacy Project was able to provide some assistance and negotiated an agreement whereby the client will move out in 60 days and the eviction will not go on his record. Derek Silva is a housing complex designed around the plan for independent living. It is staffed accordingly. Yet, many of the residents are dually or triply diagnosed. Other issues and problems come into play within their living environment, producing conflicts. The staffing plan is not designed to deal with these conflicts. This partially explains the high number of complaints. *Robert Whitford* also laid part of the blame on the harm reduction model.

The 5-Year Long Range Plan

Laura Thomas reviewed some history related to this topic. She noted that shortly after preparing the prior 5-year Plan, the HIV epidemic began changing. Needs shifted away from long-term care and hospice capacity. New drug regimens brought about health improvements for many patients, producing a need for back-to-work programs and housing options. The Council did not make revision of this document a priority item until this past year. She outlined the contents of the current document that has emerged from numerous meetings devoted to the Long Range Plan. The PWA Caucus contributed a great deal to the section entitled "Shared Values, Shared Vision" as a result of caucus discussions last August. She is now bringing this section back to the PWA Caucus in order to get more input and a sense of follow-through form the prior discussions. This

section of the document is the beginning of a chapter covering basically where we are going or where do we want to go in the care and treatment of HIV disease. Using this section as a foundation, the Council needs to then develop its plan or a set of goals and objectives to guide its work for the next five years. That is done in the Priority Setting Process. She emphasized the following themes in the document:

- Consumers need to be involved in the design, implementation and evaluation of the system.
- The system needs to be integrated: planned, developed, and coordinated as a whole.
- A client-centered system of care.
- The seven core values.

Questions from members: 1) About outreach to the homeless population; 2) About other populations with special needs; 3) About the harm reduction modality; 4) About accepting people where they're at, including people using abstinence; 5) About how the Council intends to use this document; 6) About more strongly addressing employment of People Living with HIV at all levels; 7) About residential facilities using the harm reduction modality; 8) About use of marijuana and privacy rights in the residential facilities; 9) About how important access to services is and the need to overcome disparities in access; 10) About how these values relate to advocacy efforts on behalf of People Living with HIV; 11) About non-discrimination based on economic status; 12) About the priority of serving those in greatest need; and 13) About the Reggie system.

Prioritization Organizing Committee

The PWA Caucus will continue to meet during the period of Priority Setting. Everyone is invited to attend the meetings of this body that is being set up to organize the process and carry out a smooth process that everyone can feel good about. This is a four to five-month commitment, with perhaps three extra meetings per month associated specifically with this work. The core group of this committee should be consistent in attendance. One Co-chair of the committee will be one of the Council Co-Chairs; the other will be a person recommended by the PWA Caucus. Whoever is representing the Caucus should be in a position to communicate information back to the Caucus as well as facilitate the process for the entire effort. Two members received nominations to be a Co-Chair of the Organizing Committee: Greg Neumark and Gary Harrell. After discussing the facilitator role of Co-Chair, Greg Neumark asked not to be considered. The vote was 7-1 to approve Gary Harrell. His alternate is Robert Whitford. Brad will be attending from the Housing Committee. It is hoped that Greg Neumark can attend as well.

Bylaws Recommendations

The suggested revisions were passed around for any member who missed the Planning Council meeting. Amendments can be brought up at the next Council meeting. *Greg Neumark* put forward a motion to increase the percentages of People Living with HIV in general (a majority or 50% to 67%) and of unaffiliated consumers (33% to 40%). He advocated that this group of people is the central core of the Council just as they've been articulated to be in a "client-centered" system of care and services. *Brad Hume* expressed the hope that this bylaw revision not develop into a contentious issue with non-PWA members of the Council. It should not be seen as an us-versus-them situation. He would prefer that the Caucus give some thought to how we would go about recruitment and training of new members in order to accomplish the higher levels of participation. Many members concurred that these higher percentages would better reflect the values that had just been discussed in relationship to the Long Range Plan. Most people see the need to recruit more new members from among People Living with HIV and to build greater empowerment. Jim Mitulski clarified that there would be no attempt to remove anyone from the Council. The higher percentages would be utilized to raise our sights and would express our goals. It would be implemented through gradual means. The vote was taken and was 7-1 in favor. Further information was requested from the Membership Committee.

New Business: The harm reduction modality, the severe need definition, and orientation materials.

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PWA CAUCUS – FEBRUARY 2001 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Pending
2-	Case Management	St. Mary's	Staff Conduct	Resolved
3-	Mental Health	SFGH Psych Unit (7B)	Quality of Care	Pending
4-	Housing*	Derek Silva - Catholic Charities	Quality of Care	Resolved
5-	Housing*	Derek Silva – Catholic Charities	Quality of Care	Resolved
6-	Housing	Derek Silva – Catholic Charities	Quality of Care	Resolved
7-	Housing	Derek Silva – Catholic Charities	Breach of Confidentiality	Resolved

1- Client claims that he not only received unsatisfactory services from UOP dental clinic, but also that after one year his dental needs have not been fully addressed. The client filed a grievance. UOP responded to the client's grievance with a dismissal from the UOP program and a referral to Community Dental. Client is appealing UOP's decision. The Advocacy Project, after referring the client to ALRP based on UOP's possible retaliatory misconduct, is investigating the client's claims as to what are the standards of care for the issues raised in the complaint and whether these standards where breached in this case. Additionally, the Advocacy Project is working with the client to get his outstanding dental work completed by Community Dental.

2- Client claims that he was discharged from St. Mary's dementia ward without any transition plan, except for a referral to Continuum. The Advocacy Project conducted an inquiry into the allegations as well as what is the standard of care for discharge of a mental health patient and if that standard was breached in this case. The Advocacy Project concludes that although a better discharge plan could have been in place prior client's departure, the client petitioned the court for a removal of conservatorship and self-discharged with only a few weeks warning.

3- Client claims that he was treated without professional care while a patient at the Psychiatric Unit (7B at SFGH. Client filed a grievance that included allegations of sexual harassment, breach of confidentiality, unprofessional staff conduct, false imprisonment and custodial negligence of pe property. SFGH responded with a brief reply; however, their response did not indicate whether an investigation was conducted, or what, if any, was the outcome of the inquiry. The Advocacy Project then appealed SFGH's reply asking for more information regarding concerning standards of care for staff conduct and whether they were breached in this case. SFGH then conducted a further internal inquiry and again provided a general response. The Advocacy Project has now requested more specificity to this second response and a follow-up report is to be issued soon.

4- Client filed a grievance claiming that another resident at Derek Silva entered his apartment without his consent. Client's assertions are based on his perception that some items appeared to have been moved. Client is awaiting a response from Derek Silva staff as to how they plan on dealing with his safety concerns. After an investigation, staff found no signs of entry. Client is not satisfied with the response and has decided he would be happier if he moved out of the building.

5- Client claims that he was stuck in the elevator at Derek Silva for nearly two hours with little communication from staff. With the assistance of the Advocacy Project, client filed a grievance asking for Derek Silva to develop an elevator malfunction response policy as well as investigating the delay and alleged unprofessional conduct by desk staff workers. Advocacy Project is assisting client in monitoring Derek Silva's response. Client has withdrawn his grievance as he is moving out of the building.

6- Client claims that he & his partner have applied for a two bedroom at Derek Silva many months ago while some single residents are living in a two bedrooms. Client filed a grievance as to the poli regarding two bedroom apartments and what mechanisms are in place so that the decision for housing couples are made fairly for all residents. The Advocacy Project assisted the client with the grievance and has requested a response. Catholic Charities responded in writing that a waiting list procedure is in place and that the client's 2-bedroom apartment will be available by 3/1/01 as long as the client is currently compliant with all policies and procedures of the program. Client is satisfied with the outcome.

7- Client claims that his case manager staff violates other residents' confidentiality by revealing private and confidential information. Because of such alleged breaches, client does not trust the staff and ha selected not to receive case management services on site. The Advocacy Project assisted client in filing the grievance and is awaiting a response. Catholic Charities conducted an inquiry into the alleged violations and found no conclusive evidence or documentation of any breach of confidentiality. Catholic Charities also noted that the grieving client's confidentiality was not alleged to be breached and that the alleged victims of the breach have not come forward to formally grieve. Client does not wish to appeal.

NEW CASES

	Service	Agency	Issue	Outcome
1-	Housing	SFAF	Subsidy Withdrawn	Resolved
2-	Housing	SFAF	Subsidy Withdrawn	Resolved
3-	Housing	Derek Silva	Eviction	Pending
4-	Housing*	Derek Silva	Eviction	Pending

1- Clients' subsidy is being withdrawn because of the domestic violence that has occurred between he and his partner who reside in the same dwelling place. The SFAF contends that they cannot fund an unsafe domicile. The SFAF has proposed that if the couple does not reside together the subsidy will be reinstated. Client has filed a grievance that he and his partner are engaging in court-ordered counseling and that they wish to keep the subsidy and remain in the relationship. The Advocacy Project has contacted the SFAF and they have reviewed the circumstances of the case. Upon further review, the SFAF has changed its position and the client will be able to continue living together with the subsidy intact. The client and his partner are satisfied.

2- See above.

3- Client committed violent acts and threats of violence. Client claims that these acts were not of his own volition but due to an allergic reaction to morphine. Catholic Charities served client with eviction notice. The Advocacy Project has intervened and is counseling client as to his options. Catholic Charities has proposed a withdrawal of the eviction if client seeks counseling and anger management classes. Client is considering the proposal.

4- Catholic Charities claims that client has performed violent threats to other residents, staff and destruction of property and served client with an eviction notice. The Advocacy Project assisted the client in negotiating a settlement with Catholic Charities in lieu of pursuing an eviction. The terms of the settlement are that the Client will be able to stay in his apartment for 2 months and the eviction action will be dropped. Although the client agrees to the terms of this settlement, he still believes that Derek Silva staff should be punished in some way.

* Duplicated Client

Referral Calls:	Derek Silva Grievance Procedures	3
	Private Attorney	1
	Westside Case Management Services	1
	Baker Places Housing Services	1
	Rent Board/Housing Rights Committee	1
	Peter Claver Grievance Procedures	1
	ALRP Grievance Procedures	1
	Total	9

(Report prepared by Richard Bargetto on 2/28/00)

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March Report
Housing Committee

To: Members, HIV Health Services Planning Council
Meeting Date: March 7, 2001
Meeting Place: 25 Van Ness Ave., Room 330-A

Members Present: Margot Antonetty, Hazel Betsey, Ray Combs, Mark Dunlop, Fernando Gomez-Benitez, Brad Hume (Chair), Jim Mitulski, and Ali Riker

Others Present: Chris Callandrillo, CCSAF; Carol Carbone, TARC; Amy Cunninghis, SFAF; Steven Feeback, minutes; Katherine Forbes, DPH (Housing); Daisy Leyva, DPH (Housing); George Simmons, CCASF; and Laura Thomas, AIDS Office.

Next Meeting: Wednesday, April 4, 2001, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Public comment

Brad Hume has decided to make this space available on the agenda, even though all those present are welcome to participate throughout the meeting.

General Announcements

George Simmons announced a job opening at Catholic Charities and paid tribute to Brad, Margot and others for opening the housing-shelter for gay, lesbian, bisexual, transgender, queer and questioning young adults (18-23). The facility will be accepting clients in the next few weeks. Ali Riker announced that the Mayor's Office on Homelessness has an interesting report out; it's available at their office on the Fourth floor of 25 Van Ness.

Outreach Update from DPH about housing

Daisy Leyva said that comprehensive information has been shared with the providers involved in this contract and their collaborators. Next step is to do a mailing to a broad list of housing providers. They will include a flyer that providers can hand out to clients. Daisy is the contact person in DPH. There is a concern about the newly renovated buildings not being operational yet, and the timeline is slipping. Amy Cunninghis put forward her concern about these being huge changes that impact many aspects of how clients access housing services. With the timeline slipping, how is the changeover going to be experienced by clients? She feels that there are many clients who plan on the housing voucher system to be there each year and that they will suddenly find themselves in a whole new system. She feels clients need a three-month advance notice of such changes. In a clinical setting, three months are considered the minimum lead-time for fundamental changes in the delivery of services. Daisy was also told that clients expect to be able to get questions answered during times of such changing conditions. They take their questions to Case Managers on a regular basis, so it is quite important that the detailed information reaches the Case Managers in all the service centers and ISPs.

Housing Wait List

Daisy Leyva also announced that functions associated with administering the Housing Wait List are being moved to the Department of Public Health because these functions are considered to be appropriate public functions. That change will also take place around July 1, 2001. DPH is now working with a database consultant as well as the Reggie technical staff to make sure the HWL will work well for the needs of the

providers. DPH decided this was a public agency function, as is maintenance of similar lists for Section 8 Public Housing. Daisy said this change will not result in any interruption of service: the provision of referrals to the agencies with housing or subsidy slots. She acknowledged that sometimes the referral process must take place quickly in order to get the client moved into housing quickly. Katherine Forbes is the contact person within DPH for this project. Again, extensive planning and information for providers is underway. SFAF and DPH are working closely with each other to make the transition a smooth one.

Expansion of Eviction Prevention/ALRP

Brad Hume said that he had also scheduled Bill Hirsh of ALRP for the April meeting. Brad learned that the AIDS Office had not yet provided the money for expansion of their work, and this information was subsequently verified. The amount was to be $27,000. *Laura Thomas* said she had very little additional information and referred questions to Michelle Long Dixon. She apologized for not having more information, but she is not typically involved in the program side of the AIDS Office. Ali Riker asked that the Steering Committee take a look at the last Spring Unfunds cycle and what had been recommended for funding with this "one-time-only" money. Which of those prioritized projects did get the funding? Which ones got put into contract? Margot Antonetty pointed out that things don't happen automatically; a lot of follow-up is required when it comes to handling contracts.

SRO Housing Discussion (continued)

George Simmons asked that members of the Housing Committee attend the Supportive Housing Committee, chaired by Marc Trotz. Currently, no Council members are participating. Anne Kroeneberg could not attend this meeting but will be scheduled for next month. She is the DPH representative to the SRO Task Force, an entity established by the Board of Supervisors.

Meeting Time

Brad Hume brought this issue to the committee as a result of recent viewpoints expressed against daytime meetings that conflict with work schedules *Jim Mitulski* said that there was an increased expectation that the entire Council will have more participation from HIV+ people and unaffiliated consumers. This shift in the composition of membership may necessitate changes in the way the Council functions. Some members said the current time works for them, preferring not to be out after dark in the winter months or due to their work schedules. Some members chose this committee because of its earlier meeting time. Other members were prepared to make adjustments in their schedules and respect the process of seeking additional participation from those whose jobs don't permit them to arrive at committee meetings before 5:30 PM. The timing for making such a time change was also a point of discussion. *Hazel Betsey* suggested more outreach efforts to recruit members to the Housing Committee, as a more important element than the meeting time. A compromise was suggested: leaving the meeting time as it is for the moment, while returning to this issue in a few months in order to make a more thoroughly planned decision. No one wants the Housing Committee, which deals with an issue of major importance to consumers, to be a committee that doesn't have significant participation from consumers.

CARE Council Priortization Organizing Committee

The Housing Committee needs to name its representatives, who have to be willing to take part in the effort to provide some leadership and guidance for the process of Prioritization. Brad Hume and Margot Antonetty were selected as representatives, with Fernando Gomez-Benitez and Hazel Betsey as alternates. The first meeting of the Organizing Committee will likely be taking place before the next regular Council meeting. The Housing Committee decided not to suspend its regular monthly meetings during Prioritization. A number of ideas were advanced in connection with this year's Prioritics.

Membership Committee — February Report

Meeting Date: February 22, 2001

Meeting Place: 25 Van Ness Ave., Room 330-A

Meeting Time: 5:30 to 7:30 PM

Members Present: Cecilia Chung, Carmen Madriz, Greg Neumark, Ken Pearce, Janis Takamoto, Bob Teague, and Robert Whitford

Others Present: Steven Feeback, minutes; Wayne Peace, nominee; and Jose Villarce, nominee.

Next Meeting: Thursday, March 15, 2000, 25 Van Ness, Room 330A, 5:30-7:30 PM
Meetings will generally be held on the 3rd Thursday of each month.

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Introductions and Review of Agenda

Discussion with Nominees

Ken Pearce asked Jose Villarce to go first and present some information about his background and his areas of interest. He began by saying he is applying to the Council as a consumer of services at present and for the past 10 years. He would be in a position to utilize that experience if appointed to the Council. In addition, he has been a member of the Board of Directors at Instituto Familiar de la Raza for seven years and has participated in projects with the Immune Enhancement Project, although he resigned from these activities and is not now affiliated with any agency receiving CARE funds. He intends to speak out on behalf of the Latino population and the particular HIV-related needs that he is familiar with as a member of that community. He wants to be a link between the Council and his community. He was asked about the committees of the Council and where he might like to put his energies. He responded that he would like to have the benefit of more orientation about the Council and its committees. He has the time for two meetings a month and wants to be an active participant. He has some background in Mental Health services through his work with Instituto as well as in his prior life before moving to San Francisco. His training is in psychological counseling, and he worked as a Psychologist at the General Hospital in Mexico City for many years. Outside of his job he worked with an agency dedicated to human rights for gay people and people with HIV. Between these two positions he has led groups and worked with individual clients on a range of issues, including addiction and treatment.

KP asked Wayne Peace to go next. It was noted that he had previously been a member of the Council (1994 to '96), so he was questioned about why he would want to do it again. He explained the reasons he left; mainly he was affiliated with too many activities and was experiencing too many challenges associated with AIDS, all coming at basically the same time. He moved away a few months after leaving the Council, feeling pretty burned out. He has been living with HIV for 13 years. He has the feeling of working with it on a daily basis in his own life and does not want to be affiliated with any agencies or organizations at present. Still he wants to be involved in the Council in order to advocate for himself and other people. His current job is in an after-school program, teaching young children. He said he didn't foresee any scheduling conflict with work and Council responsibilities. He is a consumer of services, having had contact with providers of substance abuse, mental health, food and housing services. Presently, he has insurance but uses ADAP, dental care and housing services. In his past stint on the Council, he was viewed as a spokesperson for youth with HIV. Members had some questions about his capacity to advocate for young people. This is something he is comfortable doing, but is no longer very connected to any of the youth groups. He is now 29 years old. He understands how difficult it is for young people to process life challenges associated with such things as HIV disease. His Council experience in the past was at a time when the funding level was

considerably higher. It was noted how much less money the Council has to work with and that there are additional struggles involved with allocations at the present time. He was encouraged to attend the next Council meeting and to take a look at the Committees.

Celilia Chung spoke on behalf of another person interested in Council membership, John McLaughlin, who was unable to attend the meeting due to the flu. He has been coming to Council meetings and the PWA Caucus. But, members would like for him to meet with the Membership Committee before proceeding with his nomination. Members wanted to ask several questions.

New Member Recommendations.

By the time these minutes are published, those people recommended by the Committee at this meeting will already have been voted up or down by the Council at its meeting on February 22nd. The Committee had some degree of discussion about one nominee held over from last month, Toni Butler. She had attended last month's Council meeting, and in the interim weeks Ken had further discussion with Jeffrey Klausner about whether or not he would be continuing in his role on the Council representing the connections between HIV and STD services. This is a position that HRSA strongly recommends the Council have, but is not a mandated seat. He reported that Dr. Klausner has agreed to resign from the Council pending the appointment of Toni Butler. He further reported his discussion related to confidentiality concerning HIV status, in that Dr. Klausner is one of a few Council members declining to disclose one way or the other. *Bob Teague* suggested that the Membership Committee could provide the Council with shorter biographical information about its recommended nominees and then report such things as HIV status in a collective manner. *Laura Thomas* stated that there is no requirement concerning disclosure of HIV status, or such things as gender/ethnicity/sexual orientation for that matter. Non-disclosing members simply don't count when we total up the unaffiliated consumers or the 50% majority of HIV+ members. That means we have to recruit enough people who are willing to disclose. *Greg Neumark* suggested a policy of disclosure while keeping this information from being public. Further, he pushed for a plan to only recommend unaffiliated consumers during this period of recruitment to the Council. There was considerable discussion of this point. *Janis Takamoto* said that the prior meeting of the Membership Committee had been prepared to recommend Toni Butler, but felt it was necessary to follow regular procedure and have her first attend a regular Council meeting, which she has now done. *GN* argued further for recommending appointment of people who really identify with the challenges faced by people living with HIV and using the range of services. He wanted to wait on votes until we further explored the possibilities of recruiting someone with the STD background and is HIV+. When it came time to vote, all three prospective new members were approved and therefore recommended for appointment. Discussion then turned to the re-appointment of John Conley for another term as representative for San Mateo County. There was a request to seek representation from unaffiliated consumers, but strong support was expressed for John Conley. He was recommended by the Committee.

Analysis of Current Membership and Areas of Representation

Laura Thomas provided a chart. She emphasized all areas of representation in reflecting the demographics of the epidemic in the EMA. She pointed to the need for recruitment of Asian/Pacific Islander members and of women members as well as the already stated need for unaffiliated consumers. She expressed the view that the Council is looking for a balance. She sees our service system as a partnership between the providers, the consumer, the funders, and the community advocates. These points of view should be expressed within the Council.

Orientation and Training

BT said he has volunteered to be the educational liaison to the Council as we go through the Prioritization process and he is willing to set up trainings in group facilitation skills, using an outside consultant. There was discussion about how some of the Council's group process is very intimidating and demanding. There was a general call for greater respect on the part of every member toward the viewpoints of other members, including those members who speak more from passions and advocacy than from knowledge of history or

skills they bring to their jobs. It was affirmed that the General Meetings are open to these viewpoints, with perhaps more time on the Council's agenda for discussion. The desire was also expressed for more extensive Committee meeting reports.

Nomination Form

JT agreed to work on drawing up a few suggested changes in the way questions are asked. Members requested copies of the current form.

Bylaws Discussion

GN brought up some amendments he wanted to suggest to the percentages of people living with HIV on the Council and of unaffiliated consumers. He appealed for support to make the percentages higher. This topic was briefly discussed without any resolution and will be put on the agenda for next month in order to have a more focused discussion. It will also be brought up in the PWA Caucus.

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Minutes, March 26, 2001 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at next meeting

I. Call to Order
4:40 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda was reviewed, then adopted by consensus.

IV. Review and Approval of Minutes
2/26/01 Council Meeting Minutes – *Laura Carcagno Guzman* requested three corrections for accuracy in the presentation she delivered. It was moved and seconded to approve the draft of these minutes as corrected; the motion passed by a unanimous vote.

V. General Announcements
Fernando Gomez-Benitez announced this was his last week working at the Mission Housing Development Corporation. Starting April 2, he will be working at Mission Neighborhood Health Center as Director of HIV Health Services. He will continue to participate on the Housing Committee. *Jim Mitulski* announced Saturday April 21 from 9-5 PM, at the Harvey Milk Academy there is a Gay/Queer Men's Health Summit; for information look it up on the web at healthyhomos@yahoo.com. *LCG* thanked everybody for their support during her tenure on the Council. She asked that people send their postings for jobs to Positive Resource Center before Craigslist in order to give HIV+ individuals trying to get back to work, first readings. With the downward economy, this is crucial for PWAs seeking employment. In addition, PRC has just started a new Employment Support Group called Just for Women. It meets the second week of each month. It has information the first hour and support the second. This group is a collaboration of PRC, AIDS Health Project and Shanti.

VI. Public Comment
Liz Butler-Stier, Acting Director of the Legal Services for Children in San Francisco, and the Hope Project that works with HIV infected families said she was here to respond to a recommendation to cut allocations by $10,000 for this year. She expressed how her program was unique and important and why they should not be cut:

1. Work with unique population that is not served widely-Families with HIV.
2. Provide Legal Advocacy for families to set up joint custody.
3. Address other legal needs for children such as Education and Access to Benefits.
4. Work with Courts on Guardianship issues and file reports annually.
5. Provide long-term Case Management to the family.
6. Provide a Family Support Group and a Peer Support Group.

There has also been an increase in requests for services. Historically there has been a problem meeting Units of Service and Unduplicated Clients, but not this year. Because clients are living longer the workload has increased. They believe the services should fall in the category of Legal Services, which was a point eventually recognized by DPH-HHS staff that was present.

VII. Reports

VIII. DPH-HIV Health Services Report
Michelle Long Dixon began by reviewing some history concerning last year's Fall Unfunds (amounts in contractor's line items not spent). The total, or HRSA carry forward amount, was approximately $770,000. Because we have been in a deficit stage for a couple of years, the majority of that was spent

to continue support of current contracts. We asked HRSA for $70,000 for specific *one-time* projects. One of the projects was for purchase of Food and Household Goods Vouchers; $18,440 was spent for the vouchers and they were awarded to 12 providers through an RFP process. The providers will receive access to the vouchers during the current fiscal year. A second component had to do with Case Management/Peer Advocacy/Treatment Advocacy. *Russ Zellers* reported that this was a new model of integrating these services into one program, and said it had not yet been evaluated. Some problems had come to everyone's attention during the past year. It was decided to request an evaluation process costing $25,000. DPH formed a Community Advisory Group and decided to contract with consultants Harder + Company to assess the Case Management/Peer Advocacy/Treatment Advocacy Model. It got started late in the year. Therefore, not all the work was completed but the work plan was put in place. Harder + Company developed a questionnaire for staff, clients, and program coordinators. It has been piloted and is beginning the interview process now. Out of the $25,000, only $10,000 was spent. HHS is now requesting that the remaining $15,000 needed to complete the project, be put in the budget for FY001/02. The end product will be an assessment, which will lead to a set of recommendations for change; this will merge with the effort to define Standards of Care. This project should be completed in the fall and needs these funds in order to finish. ***MLD*** continued presenting the projects that had been the Priority ones for last year's Unfunds. The next project she mentioned was the Eviction Prevention program (from the Housing Category). We asked HRSA for $27,000 to support this program designed to increase legal advocacy against eviction of clients. This program was supposed to be provided from November 2000 to February 2001. The contract for this service was never executed and the service was not provided. HHS took responsibility for this and said conversations to rectify the error have subsequently taken place with the appropriate provider. HHS is proposing to fund a similar program for June 2001 to September 2001 with funding from the Department of Public Health. It will not be funded through CARE. She expressed regrets that this program augmentation was overlooked and is aware that the need for this type of service continues to exist. *LCG* said that presently no ASO provides significant eviction prevention as a service to clients. The only way clients can get help presently is if they are already at the point of receiving an Unlawful Detainer action, meaning that the client does not get representation at the point of receiving Notice, but rather too close to the point of actually losing housing. She felt legal service at the point of Unlawful Detainer to be too late in the process. Overall, she said this is not an effective eviction prevention strategy. *JM* thanked Michelle for her honesty in taking responsibility for whatever it was that took place in HHS that caused this problem.

MLD predicted that this would be a difficult year because well into the new fiscal year they are still getting directives from HRSA regarding changes that come from Reauthorization to the Ryan White CARE Act. Some changes will have to be implemented after contracts are in place and it will inconvenience our providers. Communication with the providers and the Council will be important in this situation of trying to follow people who are writing the script as they go along. Michelle then went on to report that there had been conversations with HRSA regarding Congressional Black Caucus dollars, including the additional amount received in this year's award. The conversation with the funder was about "How CBC funding should be allocated? Who is an eligible provider?" Michelle reported having recently received definitive information from HRSA that this money, effective this year, must be allocated to minority-based ASOs. They are using the CDC's definition which includes those organizations having more than 50% of positions on the Executive Board or Governing Board filled by persons of the racial/ethnic group to be served. Also, having more than 50% of Key Management, Supervisory and Administrative positions (the Executive Director, Program Director, Fiscal Director) and more than 50% of the Key Service Provision positions filled by persons of the racial/ethnic group to be served. Michelle said DPH-HHS is currently funding five programs and two of the providers do not meet this criteria. HHS is in the process of determining how to maintain a level of service and still comply with the regulation and the interpretation of HRSA. In the next few months, an RFP will be issued. The structure will allow those providers who are currently providing services under the CBC program to apply. It will also allow that the additional funding received this year can be used to address the issue continually brought out in the newly reauthorized CARE Act: how to serve

people who know their status but are out of care? This RFP will help clarify the working definition of "in care," and give us the chance to address the unmet needs of clients who are currently in the system. She emphasized that the criteria used to define eligibility for receiving CBC money had come late in the process. Thus, HHS will do extensions on current programs for six months, thereby giving adequate time for the RFP, the review and the transition. They will also look for other potential funding sources for some programs that may otherwise loose their funding source. Michelle also announced a new mandate from HRSA to provide Quality Management programs. The CARE Act allows the Dept. of Public Health (the grantee) to take an additional administrative percentage from the grant in order to provide Quality Management. The current administration fee is 5%. An additional 5% or $1.7million out of a $35 million grant would be allowed. She doubts that $1.7 million will be needed in the current year to provide a Quality Management program. She emphasized that DPH is being mandated to provide an additional program for which no criteria have yet been provided. She has not yet received a letter from HRSA saying what this program has to do, how it has to do it, and how to report back to HRSA about it. It might require additional resources or staff time to fulfill HRSA's requirements. She will report back to the Council as soon as any further information is received. *Susan Shea* noted that the Reggie system is collecting quite a lot of data about clients.

Laura Thomas reported on the CAEAR Coalition Meeting in Washington DC. The CAEAR Coalition just changed its name to Communities Advocating Emergency AIDS Relief. It is a national advocacy group for Title I and Title III of the Ryan White CARE Act; SF-DPH is a member. She shared some materials that would help Council members understand the background on a variety of advocacy priorities. The goal of the meeting was to start talking with members of Congress and the Bush Administration about increased funding for Title I and Title III for this year. It is going to be a rough year to get anything out of Congress because our allies have very little leverage. HIV disease is very low on this President's agenda. The Bush Administration is cutting services for health care and children's programs. The tax cut is going to mean taking a lot of money off the table that would otherwise go to services. The CAEAR Coalition is trying a new strategy this year -- going in with a much lower request. As always, DPH will be in communication with Congresswoman Pelosi, a member of the key Appropriations Committee already working as hard as she can, but it looks like a difficult year ahead. Little or no increase to the CARE Act overall would most likely increase the chance of a reduction to this EMA in its Title I grant to be awarded later this year.

IX. Long Range Planning Report

Laura Thomas passed out a portion of the Long Range Plan, the section called "Shared Values and Vision." In general, such a comprehensive plan is a required part of the Council's function. There is another section of the comprehensive plan already written, but awaiting statistical update. Then another section is goals and objectives, which will emerge from the Priority Setting process about to get underway. The final section is an evaluation component of the plan. The plan is intended as a statement of the Council's values. These values then guide implementation decisions made by the Council, the grantee (DPH), and the service providers. These values are particularly important as a guide during the Priority Setting process. She spoke briefly about the work of the Long Range Planning Committee, an ad hoc committee of the Council. She thanked those members who worked the hardest on contributing to the formulation of this document. There were two major changes that Laura noted from the prior Long Range Plan. The first is connected to the improved health of many people living with HIV/AIDS (PLWH). People are returning to the workplace and are interested in being involved in the system of care as employees in addition to being volunteers and consumers. The second change that has happened over the last five or six years is the increasing complexity of the medical and social service needs of some clients. Serving those with the most severe needs requires an integration and coordination of services in order to provide quality care to those facing multiple challenges. Laura went on to detail other important points in the document, such as defining "client-centered system of care." Then she named the seven core values that were put into the plan and went through them individually, attempting to enlarge on the vision and the context for each value. She welcomed

immediate input about this "Shared Values and Vision" section and said that members were welcome to get involved in the writing and revision of other parts of the document. The comments received from the Council were entirely positive and supportive, agreeing that this is a very useful document expressing the mission of the Council. *LCG* wanted to make a suggestion regarding the value of Access, emphasizing flexibility in providing service, then went on to the value of Equity and recommended inclusion of non-discrimination based on immigration status or a history of incarceration among the other characteristics. Laura Thomas received a number of appreciative comments for her work on this important planning document.

X. Bylaws Revision

Jim Mitulski noted that the suggested changes to the Bylaws had been distributed to the members last month and the vote had been noticed for this evening. He invited a motion to amend the Bylaws with the objective of bringing the Planning Council into compliance with language and requirements contained in the newly reauthorized Ryan White CARE Act. It was moved and seconded. There was no discussion; so the meeting proceeded to a Roll Call vote (see Attachment A, Column 2). The motion carried 22-0. Congratulations were shared.

Another Bylaws revision had been brought forward from the PWA Caucus, and it was taken up next. *JM* said that the idea of setting higher percentages for Council participation of people living with HIV and of unaffiliated consumers was meant to be a goal that we would have a year to fully realize and that is meant to guide future membership recruitment, as opposed to affecting the status of current members. *Gary Harrell* said the Bylaws amendment being proposed by the PWA Caucus would raise the desired participation level of PLWH from 50% to 67% and would raise the participation level of unaffiliated consumers from 33% to 40%. He noted that the Shared Values and Vision document called for a client-centered system of care. He said the PWA Caucus wanted more involvement of clients in shaping the system of care. *Cecilia Chung* said this recommendation came about because it was recognized that more people want to get involved in planning bodies such as this one. It was felt that this would be a good way to increase the sense of empowerment. San Francisco has historically been a pioneer in developing responsive systems. This will encourage continued leadership from the people most affected. *LCG* noted that in the past the HRSA mandate had been 25% participation from PLWH, but the Council had set a higher objective—50%. There is precedent for going beyond what is required by the CARE Act. Many members asked to speak on this issue. *Greg Neumark* remembered the first Board meeting he had attended in his life at the Center for Independent Living. The Board was composed primarily of quadriplegics, and his father was the only person on that body not in a wheel chair. That had not always been the case. It used to be that quadriplegics didn't represent themselves in organizations that advocated for them. He spoke about Ed Roberts, the first quadriplegic to attend Cal Berkeley and went on to break down a lot of barriers. It was important for society that these barriers got broken down, even though it took lawsuits to make some of the breakthroughs and many empowerment campaigns to get higher and higher levels of participation. Especially now, when people with HIV and AIDS are trying to get back into the workplace and fighting discrimination on the job, even in ASOs, it is important that this Council make the statement that PLWH are ready to work for our own health and betterment. If we reach out more, we can find the people ready and able to serve. We can make the effort to get a cross-section of PLWH. We can build the ramps and allow people with many challenges in life to get involved. We have to have a mindset of facilitating that involvement from PLWH from more disadvantaged backgrounds. If we can't give stipends, we may have to develop creative ways of assisting the people whose involvement we seek (getting paid for the homework or do a study of PWA participation using real people as paid consultants). We have to be conscious of the sacrifice it takes for the true unaffiliated consumers to serve here. We should not be in a position of telling people to make tough choices in order to serve; we should be facilitating their involvement with appropriate incentives. *Susan Shea* also spoke in favor of this Bylaw change saying that she wants to acknowledge that we're already having a hard time reaching our participation percentages. She hopes the PWA Caucus will get more deeply involved in recruitment efforts and support the Membership

Committee with its work. *Robert Whitford* spoke about the main objective of gaining participation, but without implying that everyone is ready or able to go back to work. Not everyone is capable of holding a job. He recognized the need for this effort at greater PWA participation, but hoped that the greatest emphasis would be on recruitment of educated consumers and completely unbiased people. Some members are not as adept at all the politics that goes on within Councils such as this one and then they feel they are not able to contribute much. His concern is with people in that situation. *Hazel Betsey* challenged the PWA Caucus to bring forward more people to take seats on the Council. She felt the need for participation from very diverse populations including those who are difficult to get into care let alone into something like the Council. She questioned the need for this measure. Positive people have not been turned away. *Ken Pearce* spoke in favor of this Bylaw, while saying we would not be here today if it weren't for the tireless work of people who are themselves HIV-negative and yet have devoted so much effort to nurturing and developing services, organizations and coalition efforts such as this Council. He doesn't want to lose what they bring to the Council. He wants the Membership Committee to continue looking for people with the desire to serve and the commitment to work. Just because a person is HIV+ doesn't mean they have what it takes to attend meetings and contribute to this Council. We could load the Council up with all HIV+ people and could possibly be ineffective. He wants the Membership Committee to continue looking for people with good skills and experience rather than just being a member of a certain category or group. *Stephan Oxendine* spoke against this proposed change saying that in his three years of participation he has not seen the Council fulfill its desire to involve the disproportionately affected and historically under-served groups and sub-populations which the current Bylaws call for the Council to have at this table. He said that is not who is at the table now, and that would be a more appropriate objective. At the end of the day we need people who are going to do a rather substantial amount of work, and agreed that nobody who is HIV+ is going to be turned away because the Council is full. He wants to meet the requirements in our current Bylaws before raising the bar with respect to any of the percentages composing the Council. *GH* said it was important to send out a message of going beyond what is required. It would send a message to this community. Clearly the service system is built around the overall needs of PLWH.

LCG said she was in favor. As past Co-Chair of the Membership Committee, she said they were always looking for more PWAs as well as people who are part of communities disproportionately affected and historically under-served. This is an incredible opportunity for involvement of people who are feeling better. Ready to work should be defined as able to be active and not that everyone wants a job. The Council is primarily volunteer activity, and she wants to develop creative incentives that encourage participation. *Catherine Geanuracos* spoke in favor of the bylaw change but talked about the difficulties in finding representatives of some sub-populations in order to serve. She works with homeless youth and knows how hard it would be to get that sub-population to this table, as well as injection drug users. She wants to overcome those difficulties and still get a cross-section of the epidemic. *Jose Villarce* said he didn't want to speak about percentages but more about the desire to work. He is prepared to serve on the Council, but would not be able to go back to work. Those are two different things. *Carmen Madriz* said she wanted to speak on behalf of the people who are HIV-negative and have been working in the realm of AIDS services for more than 10 years. She said she has total respect for the clients she serves and she brings a great deal passion/compassion to this work. She is concerned about the outreach that will be needed to meet these higher objectives. We need to face reality. It is hard to find people who really want to contribute to a planning process such as this. She has daily contact with clients, but realizes that a small percentage of them are really interested in a Council or able to commit themselves. *CC* spoke again saying that there are currently people with HIV working at all service levels, which should translate into people who can represent themselves and other clients on the Council. She joined because of the obvious lack of representation by HIV+ women including transgendered women and women of color. She wants more systems to be developed for greater outreach and recruitment. She does not want to continue being the only representative of the sub-populations she just mentioned. *GN* thanked everyone who has helped him deal with his illness. He accepted a position to serve on the Council in order to say thank you for all the services, not with

any other agenda. He said we were now mandated by the CARE Act to have 14 people here who are unaffiliated consumers. This change would add two more. If we're going to take the steps to recruit and facilitate the development of the 14 people, then he believes we can go to 16 and we can find 27 HIV+ people, some of who will be affiliated with service agencies. *SO* reiterated his point about the disproportionately affected and historically under-served sub-populations not being at the table and challenged the Council's recruitment efforts to take that into serious consideration. *JM* summarized the differences of opinion and talked about the need to respect each other's views and the opposing side's viewpoints.

XI. Break

XII. Bylaws Revision (continued)

Janis Takamoto said that she thought the Membership Committee had done a pretty good job of getting qualified candidates in all categories and particularly those who are HIV+. She acknowledged how difficult it has been. For many reasons, many people feel that they are not ready to serve or get involved in this process. She reminded everyone that there are so many characteristics, which are required, mandated and desired. It is complicated to meet the representation needs of those mandates while at the same time reflecting the demographics of the epidemic in our EMA. She wants to try going beyond the percentages so far established for PWAs and unaffiliated consumers, but she is reluctant to make it mandatory on our part. *Ray Combs* said he agreed with all the arguments in favor of this change, but is still bothered because he doesn't want any kind of situation to develop where there is competition for seats between ethnic/racial communities and People living with HIV. He is a person who represents both. He really understands the difficulty in getting participation from the more disadvantaged populations with severe need. Ray made a motion to approve this bylaw change and it was seconded. A Roll Call vote was taken (see Attachment A, Column 3). The final tally was 14-7. The motion passed by the two-thirds majority that is required.

XIII. Steering Committee Report

Bob Teague passed around a brief report about the first meeting of the Prioritization Organizing Committee. There will be much more information about this in the near future. The preliminary recommendations being brought forward for Council consideration are 1) beginning in April the Council will meet twice monthly instead of once (exact dates were provided); 2) committee meetings are optional during the period of prioritization and 3) the overall plan will be submitted for a vote. *SS* emphasized the need for facilitators, consultants and staff support. The ad-hoc Prioritization Organizing Committee will function as the temporary Steering Committee during this period. *Sam Kaplan* questioned the necessity of having all meetings on Mondays, which are difficult for him. Next, *JM* invited nominations for a new Co-Chair. *SS* nominated Hazel Betsey. *Hazel* said she would accept under the condition that she would serve only until September. No other nominations were made at this time. The actual election will take place the following month in April. There was some confusion about election procedures but those will be cleared-up by the meeting in April.

XIV. PWA Caucus

Cecilia Chung said the Caucus would continue its regular meeting schedule. *JM* said that John Rosenzweig was ably fulfilling the role that Richard Bargetto had carved out. There has been no interruption in service.

XV. Implementation & Evaluation Committee

Susan Shea asked for a budget from DPH-HHS, but it had not been completed. In light of news about an additional mandate from HRSA (Quality Management), it will be necessary for the I and E Committee to take another look at its Reductions Protocol and come back to the Council with recommendations for additional cuts. She explained the two options for initial reductions and the third option, which is sending the whole thing back to committee. Many issues were clarified concerning the

appropriate category some services belonged in, the impact of the Quality Management requirements and other technical points about budgeting. It was moved and seconded to send the reductions protocol and budget issues back to committee, waiting for more information from HRSA, in order to complete the budget for FY01-02. A Roll Call vote was taken (see Attachment A, Column 4). The vote was 10-10, so it didn't pass. *SS* made a motion to approved Option #2 (with Permanency Planning moved to Legal Services category). A Roll Call vote was again taken (see Attachment A, Column 5). The motion passed by a vote of 15-4.

XVI. Membership Committee

No time left; tabled until next meeting.

XVII. Housing Committee

No time left; tabled until next meeting.

XVIII. New Business

XIX. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

March 26, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*										
2. Hazel Betsey	*HB*	P	Y	N	Y	Y					
3. Jeff Byers	*JB*										
4. Bart Casimir	*BC*	P	Y	Y	Y	Y					
5. Cecilia Chung	*CC*	P	Y	Y	N	Y					
6. Raymond Combs	*RC*	P	Y	N	N	Y					
7. John Conley	*JC*	P									
8. Mark Dunlop	*MD*	P	Y								
9. Gregory Edwards	*GE*	P	Y	Y	N	Y					
10. Catherine Geanuracos	*CG*	P	Y	Y	N	Y					
11. Fernando Gomez-Benitez	*FGB*	P	Y	Y	Y	N					
12. Gene Gowdey	*GG*										
13. Laura Carcagno Guzmán	*LCG*	P	Y	Y	Y	Y					
14. Gary Harrell	*GH*	P	Y	Y							
15. Brad Hume	*BH*										
16. Sam Kaplan	*SK*	P	Y	N	N	Y					
~~17. Jeffrey Klausner~~	*JK*										
18. Gene London	*GL*										
19. Carmen Madríz	*CM*	P	Y	N	Y	Y					
20. Michael Meehan	*MM*										
21. Allen Meyer	*AM*	P	Y	N	Y	B					
22. Jim Mitulski	*JM*	P	Y	Y	Y	N					
23. Gregory Neumark	*GN*	P	Y	Y	Y	N					
24. Stephan Oxendine	*SO*	P	Y	N	Y	N					
25. Ken Pearce	*KP*	P	Y	Y	N	Y					
26. Alissa Riker	*AR*	P	Y	Y	Y	Y					
27. Susan Shea	*SS*	P	Y	Y	N	Y					
28. Janis Takamoto	*JT*	P	Y	N	N	Y					
29. Bob Teague	*BT*	P	Y	Y	N	Y					
30. Robert Whitford	*RW*	P	Y	Y	N	Y					
31. Mary Jane Wood	*MJW*	P									

22-0 14-7 10-10 15-4

HIV Health Services Planning Council

City Hall, Room 34, 1 Dr. Carlton B. Goodlett Place

April 9, 2001 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes**, 3/26 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *Membership Committee* — **VOTE**	**4:55 PM**
	- Slate of Nominees	
	• *Overview of Priority Setting*	**5:10 PM**
	- Introduction by Laura Thomas, DPH Health Planner	
	• *Discussion of Prioritization Process Draft Plan:*	**5:35 PM**
	- Schedule for Meetings	
	- 1 or 2 Year Process	
	- Learning needs/formats	
	- What works based on past experience	
	- HRSA-mandated Needs Assessment Activity	
	- Outside training especially for newer members	
	- Provider participation	
	- Consumer input and the PWA Caucus	
	- Public comment in general	
	- Other expectations about the process	
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Mon	4/16	Implementation & Evaluation Comm.	25 Van Ness, Room 330	5:30 – 7:00 PM
Tues	4/17	Prioritization Organizing Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Thurs	4/19	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	4/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	5/2	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	5/2	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	5/7	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	5/16		25 Van Ness, Room 330	

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HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

April 23, 2001 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 3/26 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *Training Overview & Effective Council Member Participation, Bob Teague*	**4:55 PM**
	• *Introduction to Data Use and Limitations*	**5:20 PM**
	- Presentation by Stacy Hart, PhD	
	• *Membership Committee* — **VOTE**	**5:45 PM**
	- Slate of Nominees	
	• *Discussion of Prioritization Process Plan* — **VOTE**	**5:50 PM**
VIII.	**Break**	**6:00 PM**
	• *Steering Committee* — **VOTE**	**6:10 PM**
	- Co-Chair Nomination	
	• *SF Case Data and Demographics*	**6:25 PM**
	- HIV Consensus Report	
	- AIDS Case Surveillance Data	
IX.	**New Business**	**7:25 PM**
X.	**Adjourn**	**7:30 PM**

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Thurs	4/26	Prioritization Organizing Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Wed	5/2	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	5/2	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	5/7	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Thurs	5/17	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	5/21	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	5/31		25 Van Ness, Room 330	
Wed	6/7		25 Van Ness, Room 330	

HIV Health Services Planning Council, 1540 Market Street #301, San Francisco, CA 94102
San Francisco Department of Public Health, AIDS Office, 25 Van Ness Avenue, 5th floor

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Membership Committee

March Report

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Meeting Date: March 15, 2001

Meeting Place: 25 Van Ness Ave., Room 330-A

Meeting Time: 5:30 to 7:30 PM

Members Present: Carmen Madriz, and Ken Pearce (Chair)

Others Present: Steven Feeback, minutes; Edward Patterson, nominee; MJay Sanders, nominee; and Laura Thomas, DPH-HHS.

Next Meeting: Thursday, April 19, 2001, 25 Van Ness, Room 330A, 5:30-7:30 PM
Meetings will generally be held on the 3rd Thursday of each month.

Introductions and Review of Agenda

Discussion with Nominees

Ken Pearce asked Edward Patterson to go first and present some information about his background and his areas of interest. He began by remembering back to the early 80s when he was working in healthcare for a doctor in private practice and his history of volunteering. He also worked as an LVN, a laboratory assistant and as a substance abuse counselor, then became a Social Worker. He worked at Acceptance Place and broke new ground by bringing in Transgender services. He wants to join the Council in order to insure that everyone gets equal access to services. The majority of his work has been in the Tenderloin neighborhood with very marginalized populations, such as Transgenders and the homeless. He developed very poor health, dealing with Hepatitis C as well as HIV. For a year or so he could not get involved in anything beyond his personal health and survival. Since he has gotten stronger he has found himself missing the involvement of political and community work. The Council is something he can do to help other people and to help himself. He has watched many of the services go through their changes. He has been a consumer of services and a caregiver as well as a service provider prior to retirement. He was asked questions about the communities to which he feels most connected, his work history as an LVN, his administrative work in a medical clinic (for people over 60 year old in Berkeley) and his recovery from the loss of past partners to AIDS-related deaths. He expressed how much a bereavement group helped him. He has experience with CSAS task forces and planning groups, including service for a time as a Co-Chair. He talked about keeping focus in meetings and getting participatory input in planning processes. He learned a lot about coping with group process and building consensus in the give-and-take of community planning. He expressed that he has ample time to give to the Council and he is willing to make the commitment. He intends to start taking part in meetings and committees.

KP asked MJay Sanders to go next. He started with how he first became aware of the Council, which was when he joined the staff at Visiting Nurses and Hospice, a part of California Pacific Medical Center. He worked for a senior management person and through that had knowledge of the funding streams, including Ryan White CARE funds. He was doing dome direct administration of contracts when he left in late 1994 to go on disability. He talked about the loss from AIDS-related deaths among friends and family. He is now looking for an opportunity to serve and to make a contribution to the service system. His professional history is filled with instances in which he rose through the ranks rather quickly because he takes initiative to get things moving and to learn what's necessary in situations of inter-personal communication. He feels strongly about making things work within the context of funding requirements and the importance of fulfilling the criteria to maintain funding. He believes he can identify with groups at the bottom of the socio-economic ladder because he has experience in collaborative efforts to build programs to meet the needs of disenfranchised populations. He has learned a number of techniques for reaching out beyond his particular

background, and knows he can maintain his enthusiasm for this work. He is a consumer of services, particularly ADAP, benefits counseling and mental health. He was encouraged by committee members to get involved in the work of the Council and to learn about areas of the service system with which he is less familiar. He was told that his being unaffiliated with any agency and his having no conflict of interest was viewed as an advantage at this time.

New Member Recommendations

One of our nominees now before the Mayor has already resigned because of housing difficulties in San Francisco. Moving to San Diego, he will be missed here, and his name will be formally withdrawn. Both candidates interviewed today, and reported above, were recommended for Council approval. That is also true for the recommended reappointment of Sam Kaplan. Many of the newly appointed people not yet formally appointed by the Mayor have begun attending committees and Council meetings. Everyone agreed to provide more support and encouragement to them. It can easily become discouraging when you are prepared to serve and do not hear about a Mayoral appointment. (Since this meeting took place, another new nominee has withdrawn his name from consideration by the Mayor, that being Derrick Mapp.)

Analysis of Current Membership and Areas of Representation

The needed categories and the ones for which the committee is actively recruiting are HIV+ women, HIV+ Latinos and HIV+ Asian/Pacific Islanders. The Membership Committee is committed to finding well-qualified people to serve.

Representation on the Prioritization Organizing Committee

Ken and Carmen both supported Greg Neumark to be the Membership Committee representative on the work group for Priority Setting.

Nomination Form

Steve Feeback agreed to prepare a draft of a new Council Member nomination form, based on the suggested changes brought to the meeting by Carmen Madriz on behalf of herself and Janis Takamoto.

Attendance Figures

Steve Feeback brought a report (since updated through the end of first quarter 3/31/2001) about Council member attendance during the First Quarter of 2001. The highest achievers were as follows:

> Brad Hume	14 meetings
> Greg Neumark	11
> Gary Harrell	10
> Jim Mitulski	10
> Susan Shea	10
> Cecilia Chung	9
> Ray Combs	9
> John Conley	9
> Bob Teague	9
> Robert Whitford	9

There were also a couple of members falling well below the minimum attendance required to stay in good standing. Some members will be receiving letters about their low attendance and may be placed on probation.

HIV Health Services Planning Council
Implementation and Evaluation Committee

March 19 Report

Meeting Date/Time: Monday, March 19, 2001, 5:30 – 7:00 PM

Members Present:

Susan Shea (Chair), Brad Hume, Mark Dunlop, Mary Jane Wood, and Cecilia Chung.

Others Present:

David Macias HHS; Karen Wuopio Marin County AIDS Services and Council nominee; MJay Sanders Council nominee; Joseph Cecere HHS; Toni Butler SFDPH and Council nominee; Marshia Herring HHS; Laura Thomas HHS; Russ Zellers HHS; Michelle Long Dixon SFDPH/HHS; Derrick Mapp African AIDS Network; Marcy Fraser Continuum; Steve Kohlstrom Continuum; George Simmons CCASF; Chris Callandrillo CCASF; Tim Patriarca Maitri; Pam Sims SFRA; Jim Illig Project Open Hand; and Nan O'Connor CSP.

Next Meeting: Monday, April 16, 2001, 5:30 PM, 25 Van Ness Ave., Room 330

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Call to Order
SS gave a call to order.

Introductions
Participants present introduced themselves.

Review and Approval of Agenda

Unfunds
SS reviewed the Unfunds Policy and Procedure. She shared a handout and explained the basic background about Unfunds.

2000 Spring Unfunds - update by HIV Health Services

Spring Unfunds are funds that become available when contractors are not able to use the full amount of the money in their contracts during the budget year. On an annual basis, the amount is not usually known until May. *SS* shared that last year, Spring Unfunds, also known as Rollover funds, were used to cover a deficit of $500,000, which was a result of the reduction in the Title I Grant for FY00-01. She also shared the list of projects in priority order that was to be used in guiding HHS in the use of any Rollover funds beyond the amount covering the deficit. *MLD* said in her report to the I&E Committee in September that HRSA had approved the request for the projects on which Unfunds would be used: $25,000 for Case Management Task Force, $18,000 for buying Food and Household Goods Vouchers and $27,000 for Legal Advocacy. This includes program enhancements for Housing and Adherence Assistance and covers up through project #3 on the Council's priority list.

The amount for vouchers (#3 on the list) has been put into contract after issuing a RFP. This process allowed a greater number of agencies to apply for vouchers, both those already purchased in past years and the new ones purchased as part of this priority listing. This contract will be part of the FY2001-02 cycle. Priority #2 – Eviction Prevention is a program that unfortunately was not put into contract due to an oversight in HHS. The funding was intended to go into a specific contract, but never made it into the contract revision process. There have been negotiations with that contractor and they can still fulfill the objectives and want to provide the service. Logistics concerning a timeline and finances are in negotiation. The opportunity to use CARE dollars has been lost, but General Fund dollars can be allocated to this contractor from the current year budget. Marshia Herring, Program Manager, explained that the intent of this program was to free up time on the part of two attorneys dealing with eviction prevention. This funding would provide those attorneys with three interns who will do many of the intakes, court filings and administrative necessities so that the attorneys can have more time focusing on the advancement of cases. In addition, they would like to publish a booklet regarding housing issues in San Francisco. Priority #1 had been listed as Case Management. An amount of $25,000 was approved by HRSA to use for a consultant to work with DPH-HHS on a project to examine problems with service provided under the rubric of Case Management, Peer Advocacy and Treatment Advocacy. An

Advisory Committee was formed and a work plan was developed. They hired Harder +Company to manage the work plan. They have developed a questionnaire, piloted it and are administering it to clients, staff and program directors of agencies that provide those services. There is $15,000 remaining. *Russ Zellers* explained that he would like to make this money available immediately so that it does not become part of Unfunds and a subsequent Rollover request, which would mean a major interruption in the consulting effort. DPH-HHS staff pointed out how complex is the web of services and that the funding streams supporting these services very complex for them to administer.

2001 Fall Unfunds – update by HIV Health Services

SS said that present knowledge indicates there are no Fall Unfunds. At this time, it appears that contractors used all of their money. *MLD* said there is a report that comes out weekly so the dollar amount is still being refined, but it appears that all or nearly all available funds have been spent.

Funding for FY2001-02

a) HHS Staff detailed the current draft figures for the current fiscal year that began March 1. Many of the precise amounts are still undergoing revisions, but the deficit is projected to be in the neighborhood of $440,000, of which $200,000 can be covered by new State monies for Program Support (TA and Training). DPH-HHS has applied the CARE Reductions Protocol previously agreed upon by the Council, and these figures were presented as part of their proposal. These proposed reductions are the result of "utilization issues ongoing over multiple years" as well as the closure of one Case Management program. These cuts would affect four service categories including Substance Use, Health Care and Respite Childcare, in addition to Case Management. Target populations were identified for each of these service categories. These programs had not met their projections for Units of Service or Unduplicated Clients.

b) Demographics of the four categories

i) ✦ Substance Use. The program targeted for reduction had a budget for FY00/01 of $161,926 and the proposed reduction is $75,000 or 46.3%. There are three other programs offering services to the same target population (Gay, Bisexual, Transgender Un/Under insured, HIV+ low-income residents receiving individual and group substance use counseling). Clients have been transferred into other programs and funding sources. *MLD* explained that the trend indicates that over the last few years, this program consistently under-utilized their funds and negotiations have taken place to reduce this contract.

2) ✦ Health Care. The program targeted for reduction had a budget for FY00/01 of $84,513. The cut is $12,650 or 15%. The target population is HIV+ Asian Pacific Islanders who are multiply diagnosed, low or very low income and marginally housed. This is a newer program that is part of an integrated setup, and the clients are getting their services through another part of the integration.

3) ✦ Respite Childcare/Mental Health. The program targeted for reduction had a budget for FY00/01 of $300,231. The cut is $15,000 or 5%. This is the only program supplying this service for low-income SF families with an HIV+ member and children under 13. The Program Manager said this contract had left unspent significantly more than $15,000 over the past three years. Respite care is not childcare in the traditional sense. It is set up so that the responsible adult in a household may go to a medical appointment or get a break or for someone to take the kids to the park etc. It serves approximately 50 families.

4) ✦ Case Management. The program targeted for reduction had a budget for FY00/01 of $65,128. This program is recommended for closure. It was a Detox Case Management companion piece to a program at San Francisco General. Both were phased out. Future plans are to create outpatient capacity for detox treatment rather than an inpatient program and continue to serve HIV+ clients with coexisting substance use and psychological disorders.

c) Review of CARE Reductions Protocol and Core versus Non Core Services

1) First level of Reduction – New programs not yet funded. These programs were planned but not started.

2) Second level of Reduction – Would reduce programs that under utilize contractual funds.

3) Third level of Reduction – Contractual performance criteria = defund or reduce funding for programs that receive "needs improvement or unacceptable monitoring reports."

4) *SS* reviewed Core and Non Core budget categories. Non-Core categories are Pharmaceuticals, Childcare, Adoption/Foster Care, Transportation, and Planning Council Support. The four service categories above (Substance Use, Primary Care, Mental Health and Case Management) are Core.

Discussion and Proposals for Making up the Deficit

By way of introduction, *SS* said that it is important to acknowledge that just because a program in a Core Service category is not meeting its contractual objectives, the target population to be served by that program is still in need of services. Thus, it would perhaps be better to leave the money in the category and shift it somehow to

make use of the funding for that target population in the context of a program able to meet its objectives. She suggested we should try to find Non Core programs that can absorb cuts because they are less essential to the life of a client in our service system. She began trying to identify such programs:

a) The first of these would be Pharmaceuticals. *SS* said she believes the HIV+ population has other access to medications through ADAP or Medi-Cal. She suggested a reduction of $104,781 (probably not a precise final figure, pending the CARE Title II award and any reductions necessary due to shortfall in Title II).
b) The second Non Core budget category is Childcare. *SS* suggested a 15,000 cut. Council members, Service providers and HHS Program managers put many viewpoints forward. Childcare is sometimes used as respite care. Issues regarding the low pay and status of the workers had previously been addressed and improved. *MLD* said that it is best to carefully analyze this category in another session without specific dollars attached, such as during the priority setting, and give it more attention than can be presently done. This issue should be flagged and dissected during the prioritization. After more clarification, there was support for the $15,000 cut from this program. This will be an issue in prioritization partly due to higher numbers of people going back to work.
c) Adoption and Foster Care. Joseph Cecere, Program Manager, said this service is for Permanency Planning (the family decides who will raise the kids upon death). It was supposed to have been moved it into the category of legal and immigration services. This makes a difference in terms of whether it is viewed as a Core or a Non Core Service. The program received a funding reduction last year. It was questioned whether they could handle a further reduction. *SS* suggested a cut to the budget in the service for Permanency Planning that used to be Adoption & Foster Care, approximately a $10,000 reduction. This might require separating it into a sub-category of Legal and Immigration Services.
d) Transportation is a Non Core service and that is why it is included here. Russ Zellers said that in the last prioritization, it was recommended to expand transportation to allow rides in the evenings for support groups and other meetings. This is van transportation used by disabled HIV+ clients. There was considerable sentiment against any reduction here. *SS* disagreed and said she felt more money could come out of the General Fund for this service. She did not know where the Committee could find another $100,000 in reductions unless it resorts to cutting Core services. Marcy Fraser said that she understands that there is less transportation available to HIV+ clients since recent changes in the Para Transit system. *Mark Dunlop* argued for the importance of Transportation to the clients whose medical care would suffer if they did not have rides to their appointments. Even a $5,000 cut was objected to by some of those present. *SS* suggested that this Committee could not revise the policy of the Council on Core versus Non Core services. If the debate is between the cuts in four Core categories above or these five Non Core categories, then in her view we must resolve to make the Non Core cuts first. *MJW* saw this as a debate between cutting a Non Core service category that is being fully utilized or cutting a Core service category in which there are under utilized programs. She suggested a little bit out of this and a little bit out of that. She favored a spirit of compromise. She also favored doing things that make administrative sense due to the way contracts are structured.
e) The final Non Core category is Planning Council Support. *SS* asked if the Planning Council staffing line item has been utilized and what projects may be needed for evaluating the service system in the next year. These were hared questions to answer. *Laura Thomas* said the Council should look carefully at the past year's budget and new reporting requirements from HRSA that may involve more work in the area of administrative support by note-takers. There are also requirements related to Needs Assessment, which is mandatory, as well as gathering consumer input in forums such as the Tenderloin Community Forum. The Prioritization process may also lead to additional demands on the Council Support budget. *SS* said that the Council Co-Chairs were supposed to bring information about the Council Support budget to this meeting, but were not present tonight. She proposed a $50,000 out of this category. *MLD* reminded everyone about the Rollover or Spring Unfunds and said the Council may be able to use one-time funding for the types of projects we have historically included in the Council Support budget, such as Needs Assessment activities. We can ask HRSA to approve such a use of Rollover funding.

After this discussion *SS* decided that there was not support for a cut in Transportation and said she would talk to the Co-Chairs about cuts in the Planning Council Support budget. She reviewed some of the options available for covering our deficit in funding for FY2001-02: deficit spending, or reductions, or a combination of both. The cuts can be handled in a variety of ways, but *SS* decided to construct a detailed motion.

2. **Motion to be sent to Council**

Motion: The I&E Committee would recommend to the Planning Council that programs with utilization issues be de-funded according to the amounts suggested by the AIDS Office and negotiated with the service

providers. That same amount of money would then be reallocated within the same category or sub-category and distributed across the category to all Contractors doing the same services. Second, to cover part of the deficit we will remove $XX from Pharmaceuticals, depending on the amount of our Title II Award; take $15,000 out of Childcare per the AIDS Office suggestion based on under-utilization; take $10,000 out of Adoption/Foster Care (Permanency Planning); decrease the Planning Council Support budget by $XX to be determined by the number of projects that can be taken out of that budget and put into the Rollover request. The rest of the deficit would be requested for deficit spending and covered by Rollover dollars. Mark Dunlop seconded the motion.

The vote of Planning Council Members was as follows (there were 5 eligible voting members present): Mark Dunlop, Susan Shea, Cecilia Chung, Brad Hume and Mary Jane Wood all voted yes. It was a unanimous vote in favor of the motion. Another vote was taken in order to include all those present in the meeting, and it received near-total support.

Other Agenda Items:

- Budget for 2001-02 - Tabled
- Co-Chair Status - Tabled
- Representation to Prioritization Organizing Committee - Tabled
- New Business – Tabled

Meeting adjourned at 7:15 PM

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April Report - PWA Caucus Meeting

Meeting Date:	April 4, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:00 PM
Members Present:	Cecilia Chung (Co-Chair), Gary Harrell (Co-Chair), Brad Hume, Greg Neumark, and Bob Teague.
Others Present:	John Rosenzweig, HIV Consumer Rights Advocacy Project; Steven Feeback, minutes; Kevin Johnson, consumer/staff; and Edward Patterson, Council nominee and consumer of services.
Next Meeting:	Wednesday, May 2, 2001, 25 Van Ness, Room 330-B, 5:30-7:30 PM

Welcome and Introductions

Cecilia Chung called the meeting to order. Members introduced themselves and approved the meeting agenda.

Announcements

Brad Hume made a brief report about levels of funding contained in the just-released federal budget plan of Pres. Bush for the Ryan White CARE Act. San Francisco is very likely to receive a cut in its Title I grant this year; and the more likely that will be under what is called "flat funding," which is what Bush has sent to Congress. Brad also announced an upcoming Forum on Housing Issues for People with HIV and AIDS. The Forum is hoping to hear from providers, advocates and individuals living with HIV disease who want to testify before a panel of decision-makers, including two Supervisors and directors of major City agencies. The Forum will be held May 31st from 1 to 3 PM. It will be at the SF Main Library. His third announcement had to do with the content of the Housing Committee meeting just completed. The Committee invited Ann Kronenberg of DPH to give an update on the SRO Task Force. Brad said he was somewhat encouraged by the information he heard from Ann. The SRO Task Force will be issuing its first report of activities very soon. Then, on May 15th the Task Force will be presenting its plan to the Board of Supervisors. Further action is needed and planned for the upcoming year of work. *Gary Harrell* asked Brad if there was any new information about the changes in emergency housing vouchers and the plan to inform consumers about the changes. Brad said he anticipated some new information in the next few weeks going out to providers and consumers. Work is very advanced on the three renovated buildings and the transition date is still set for July 1, 2001. *CC* asked Brad if DPH-Housing Services would be presenting to the full Council between now and July 1st. Brad responded that the Housing Committee is going to start working on an extensive presentation of Housing-related stuff, and that will be delivered to the Council in the context of the Priority Setting process. *CC* advocated that further information about changes in emergency housing vouchers be provided prior to the Housing presentation as part of the Prioritization process.

Report from the Consumer Rights Advocacy Project

John Rosenzweig provided his report covering the month of March 2001 *(see attachments)*. John said Richard had done an excellent job of wrapping up many of the cases before taking his Leave of Absence. John ran through the new cases that came up over the course of the month he has been working in Richard's place. He highlighted a few of the new cases. The first client he mentioned has experienced years of

difficulties at UOP Dental School. The client now seems satisfied that his issue about the quality of care was recognized by UOP, and the client accepts responsibility for the role that some of his confrontational behavior has played in the service problems. The second client had lost a subsidy opportunity at Catholic Charities and had worked with Richard on a grievance. John expressed his view that more important than the grievance was re-instatement of his opportunity to receive this service from Catholic Charities (payment of past-due rent). Now, it appears there is satisfactory progress. The third client complained about an unauthorized disclosure of his medical history by a staff member at Catholic Charities. The client also says he has not received adequate support services in his housing search. This case is unresolved because the client also may not trust the services of the HIV Consumer Rights Advocate, preferring instead to pursue his grievance with the SF Human Rights Commission. The fourth new client had two similar complaints, one against AIDS Health Project and the other against SF AIDS Foundation for not allowing a telephone intake at a time when he was suffering from severe fatigue, weight loss and limited vision. This case may involve denial of reasonable access to service and/or reasonable accommodation of his medical condition. It is still pending. In the meantime, the Advocacy Project also contacted the ALRP to arrange for an expedited referral for the service of preparing a will and powers of attorney, due to the client's medical condition. There is clearly a need to clarify with some agencies when it is appropriate to utilize telephone intake procedures.

Recruitment Issues for Council Membership

Bob Teague passed around some materials related to recruitment of People living with HIV in order to help the PWA Caucus fulfill the recruitment and membership goals of the newly reauthorized Ryan White CARE Act and the just-revised Council Bylaws. Bob is committed to ensuring that new Council members receive adequate orientation and training. He ran through some of the hand-outs, documents generated by HRSA. He considered this material to be good background information. He wanted the Caucus to help address the ongoing dilemma of how to get qualified people into the door and at the table, then effectively participating in the work of this Planning Council. Every Council in the country faces these issues related to its nomination process and orientation of new members. Therefore, some of these HRSA-generated materials attempt to summarize the experiences of other groups. Perhaps there are some ideas we can use or adapt to our needs here. Obviously, recruitment and retention efforts are an ongoing effort and are everyone's responsibility. Many techniques and potential ideas from other EMAs are listed. *Greg Neumark* said he wanted to debate the Planning Council's Support Budget in order to insure that there is adequate money available for Council outreach, recruitment and retention efforts. He wants to increase the Council Support Budget. He doesn't believe this budget has ever had significant input from very many Council members. He believes control of this budget has been "handed off" before and does not want to see this continue. The PWA Caucus is very concerned about supporting all the recruitment efforts and welcomes communication with the Membership Committee.

Priority Setting Process

Bob Teague explained some of the basic precepts of this process. This time we will not produce a "wish list." It will be goals and objectives—things we can then check to make sure the action steps are in place. He talked about the schedule and the overall plan with data, research, learning materials, presentations, etc. Everyone thanked Bob for bringing materials and information.

Forums

Everyone wanted to do outreach events and consumer input activities. The only debate was about the type of event, the neighborhood, the focus on prioritization or not or a focus on dental care, the dates, the locations, the workload, the intensifying meeting schedule for the Council. It is expected that the Caucus will be central to the consumer input component. We would like other members of the Council to help out and contribute. *BH* said that many people are looking to the Caucus to take a lead role. He thinks it is crucial to get information from the community. He hopes we can find good methods that don't over-burden Council staff with details of organizing. He supported the idea of using other forums that are already planned by other

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PWA CAUCUS – MARCH 2001 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Pending
2-	Mental Health	SFGH Psych Unit (7B)	Quality of Care	Resolved
3-	Housing	Derek Silva	Eviction	Resolved
4-	Housing*	Derek Silva	Eviction	Resolved

1- Client claims that he not only received unsatisfactory services from UOP dental clinic, but also that after one year his dental needs have not been fully addressed. The client filed a grievance. UOP responded to the client's grievance with a dismissal from the UOP program and a referral to Community Dental. Client is appealing UOP's decision. The Advocacy Project referred the client to ALRP based on UOP's possible retaliatory misconduct, but the attorney he was referred declined to take his case. The Advocacy Project is investigating the client's claims as to what are the standards of care for the issues raised in the complaint and whether these standards were breached in this case. Additionally, the Advocacy Project is working with the client to get his outstanding dental work completed by Community Dental.

2- Client claims that he was treated without professional care while a patient at the Psychiatric Unit (7B) at SFGH. Client filed a grievance that included allegations of sexual harassment, breach of confidentiality, unprofessional staff conduct, false imprisonment and custodial negligence of personal property. SFGH responded with a brief reply; however, their response did not indicate whether an investigation was conducted, or what, if any, was the outcome of the inquiry. The Advocacy Project then appealed SFGH's reply asking for more information regarding standards of care for staff conduct and whether they were breached in this case. SFGH then conducted a further internal inquiry and again provided a general response. The Advocacy Project requested more specificity to this second response and a follow-up report providing more specific answers was issued indicating that SFGH has reviewed its policies and procedures, and has counseled staff on appropriate conduct. Client is satisfied that his grievance has been aired and does not wish to pursue the grievance any further.

groups. *GN* talked about the Housing Forum sponsored by ALRP. We should try to work with them and perhaps get an additional bit of input about our needs. *GH* pushed for returning to the Tenderloin in order to give some response to those who attended the prior event, especially about the SRO hotel conditions. *CC* asked that we stick to what is realistic. She asked that we try to give each other more support in these meetings, trying to avoid cross-talk as part of the meeting. She also talked about her limited time during these months. *BH* talked about the need to be honest with the rest of the Council about what we can realistically do and how much energy we have for this work of getting input about services from a greater variety if consumers. *GN* asked for attention to the upcoming votes about Priorities and Allocations to Service Categories. Once we focus on the need to have a good idea of what consumers need and want, we will see the need for input about how we vote on those issues in August. We really want public comment and consumer voices to be heard. Edward Patterson summarized the proposition on the floor about calling for a forum for PWA community input before Prioritization is completed. It passed 3-1 among voting members of the Council, with the one person opposed (Brad) saying he was not committed to one forum but rather several strategies for getting input. *GN* asked that we consider doing a forum on our own and trying to organize other input activities with others. He hoped these concepts were not mutually exclusive. He moved that we go ahead and ask to take part in the ALRP forum, while investigating other venues and opportunities for getting input during the process known as Prioritization. This motion also passed. Some wanted to form an ad-hoc committee to work on this. It will be on the agenda again next month.

Harm Reduction

CC said she has asked Bob Teague to prepare some materials on the history of this and how it is handled in other countries. She would like to see some education take place.

New Business: same as last month.

3- Client committed violent acts and threats of violence. Client claims that these acts were not of his own volition but due to an allergic reaction to morphine. Catholic Charities served client with eviction notice. The Advocacy Project intervened and counseled client as to his options. Catholic Charities withdrew the eviction notice after the client apologized to the other residents and staff and signed releases allowing Catholic Charities staff to share information with his caregivers.

4- Catholic Charities claims that client has performed violent threats to other residents, staff and destruction of property and served client with an eviction notice. The Advocacy Project assisted the client in negotiating a settlement with Catholic Charities in lieu of pursuing an eviction. The terms of the settlement are that the Client was able to stay in his apartment for 2 months and the eviction action was dropped. The client moved out of his apartment as required by the settlement agreement.

NEW CASES

	Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Pending
2-	Housing	Catholic Charities	Access to services	Pending
3-	Housing	Catholic Charities	Unauthorized Disclosure	Pending
4-	Other	AHP	Access to Services	Pending
5-	Other*	SFAF	Access to Services	Pending

1- Client claims that he has been mistreated by staff and professionals at UOP over the past few years, and that inappropriate notations have been made in his dental charts regarding his behavior. Client believes these notations have given him a bad reputation at UOP, and that he would be subjected to further mistreatment if he were to continue as a patientat UOP. Client filed a grievance against UOP regarding several alleged incidents of mistreatment and improper notations, and UOP has responded in detail. The Advocacy Project will meet with the client to determine if he is satisfied with UOP's response, or if he wishes to pursue his grievance.

2- Client claims that Catholic Charities denied him a housing subsidy because they could not reach him by telephone. Client has voice mail, but no telephone service. Catholic Charities staff left client a series of messages informing him he had qualified for a housing subsidy to pay past-due rent, and asking client to call to set up an intake appointment. Client returned the telephone calls, but could not reach the person who left the messages, and left a series of messages for Catholic Charities staff informing them when he would be available to come in. When client finally reached the staff person by telephone, she informed him that the subsidy had been awarded to someone else. The client filed a written grievance on his own, then contacted the Advocacy Project for assistance. The Advocacy Project contacted Catholic Charities and arranged for the client to reapply for the subsidy under revised procedures. Client has not decided whether he wants to further pursue his grievance.

3- Client claims that staff at Catholic Charities made an unauthorized disclosure of his psychiatric history to the president of the tenants association of a building into which he was planning to move. According to the client, this disclosure damaged the client's reputation and denied him potential housing, since he feels that he could not live in a building where residents know his psychiatric history. Client also claims that Catholic Charities has done an inadequate job of finding him housing where he can use his housing subsidy, and that SRO hotels to which he was referred were uninhabitable and too expensive. Catholic Charities maintains that it does not find people housing,

and does not vouch for the quality of the hotels to which it refers clients. The Advocacy Project assisted client in drafting a grievance addressing his concerns, and attempted to facilitate communications with Catholic Charities regarding his immediate housing needs. Client has elected to pursue the grievance with the San Francisco Human Rights Commission.

4- Client claims that AHP created barriers to its services that amounted to a denial of reasonable accommodation. The client had requested a telephone intake due to severe fatigue and limited vision, and AHP insisted that he come to its office for three separate appointments before he was referred to a therapist, and then required him to wait four to five months for an appointment. Client feels that the therapist he was assigned to provided inappropriate counseling. According to the client, the therapist also refused to accommodate his request for a two week break in his therapy sessions, claiming it was AHP's policy not to allow such a break. The Advocacy Project is assisting the client in preparing a grievance addressing the issues raised by the client's experience with AHP.

5- Client claims that SFAF created barriers to its services that amounted to a denial of reasonable accommodation. According to the client, who has severe fatigue and limited vision, the SFAF required him on two separate occasions to come to its offices for services that could have been provided over the telephone or at his home. When he arrived for these appointments, he was required to wait 45 minutes for the first appointment and 1½ hours for the second appointment. The client also believes he was misinformed about the services to be provided at the second appointment, which he believed was for the purpose of meeting with an ALRP attorney to prepare a will and powers of attorney. The appointment was in fact with an ALRP staff attorney to do an intake for referral to a volunteer attorney within two to three months. The Advocacy Project is assisting the client in preparing a grievance concerning the SFAF's procedures. The Advocacy Project also contacted the ALRP to arrange for an expedited referral due to the client's medical condition.

* Duplicated Client

Referral Calls:	ALRP	1
	Kaiser	1
	PRC/SFAF	1
	Community Dental	1
	Bank of America	1
	HIV Immigration Law Project	1
	Total	6

(Report prepared by John Rosenzweig on 4/4/01)

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Housing Committee Meeting Minutes
April 4, 2001

To: Members, HIV Health Services Planning Council
Meeting Date: April 4, 2001
Meeting Place: 25 Van Ness Ave., Room 330-A

Members Present: Margot Antonetty, Hazel Betsey (Co-Chair), Catherine Geanuracos, Brad Hume (Co-Chair and minutes writer), and Ali Riker

Others Present: Chris Callandrillo, CCSAF; Amy Cunninghis, SFAF; Steven Feeback, staff; Bill Hirsh, ALRP; Kevin Johnson, staff; Ann Kronenberg, DPH; Daisy Leyva, DPH (Housing); George Simmons, CCASF; John Rosenzweig, HIV Consumer Rights Advocate; Jason Stein, ALRP; and Laura Thomas, DPH-HHS.

Next Meeting: Wednesday, May 2, 2001, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Announcements

Brad Hume announced that Ann Kronenberg would not be able to come until 4:00 p.m. *Hazel Betsy* announced that she is stepping down as Co-chair of the Housing Committee in order to serve out the remainder of Laura Guzman's term as council Co-chair. *Ali Riker* suggested that we put off nominations for a new Co-chair until May and that someone asks Catherine G. and/or Fernando G. if they are interested. *AR* said that if the committee were in a bind, she would resume her role as Co-chair.

Laura Thomas distributed an "Action Alert" about the President's proposal to flat fund the Ryan White CARE Act. She encouraged everyone to call their senators and ask them to speak out about this proposal. This proposal also affects federal funding for other health related programs, including services for children. *Brad Hume* asked how dollar amounts are appropriated for CARE funds. *LT* said that the Act is authorized for a period of five years, but funding is appropriated annually.

Eviction Prevention Update from ALRP

BH announced that the $27,000 designated for eviction prevention would be coming out of the General Fund so that the ALRP's project can start this summer. He thanked the AIDS Office for making this happen in a timely manner. He also reminded the members present about conflict of interest and what the committee needed to hear was information related to the types of housing services clients need when they come to ALRP trends that staff have identified, and perceived community needs. The meeting was not an opportunity for a program sales pitch.

Bill Hirsch gave a summary of ALRP's work and introduced Jason Stein, one of the two housing attorneys. Evictions are the most compelling cases ALRP sees. In the last four years, the number of clients needing housing-related assistance has doubled. Last year approximately 400 clients came to ALRP for housing issues and almost 200 of these clients received direct representation from ALRP. Approximately 80% of clients presenting with housing problems remained in their home 10 months later. The short-term project will begin this summer with the hiring of several law clerks to assist with client intake, research, and writing publications for PWA's with housing issues. Bill Hirsch announced that ALRP received funding from HUD that will allow staff to do presentations on fair housing for providers

and to hold a PWA housing forum on May 31, 1-3 p.m., at the Main Library. They are hoping that PWA's will attend and give public testimony. A number of decision-makers will be present to receive to the testimony. Bill Hirsch asked for the committees' endorsement of the forum and assistance in outreach to consumers.

Jason Stein stated various reasons why clients are in danger of being evicted, e.g., landlord's refusal to accept subsidies, habitability issues, no-pet policy which affects clients with emotional support animals, nuisance issues, roommate conflicts/master tenant evictions. The earlier the client received some intervention, but better able ALRP is to prevent an eviction. Some cases are resolved quickly with a simple letter or referral, while others may require litigation.

LT asked if ALRP is working with other groups that are addressing habitability issues in SROs. ALRP will be attending the SRO Task Force. ALRP does not usually have a role until there is a specific legal problem. She asked what the Council, with it's limited leverage around SROs, could do. *Margot Antonetty* asked if ALRP communicated differently with agencies that provide HIV funded housing services. All CARE funded agencies are informed of the role of the Consumer Rights Advocate. ALRP tries to mediate issues as much as possible and can be helpful in attaining "reasonable accommodations" for clients with mental health or other non-HIV specific housing issues.

It was asked what geographic area ALRP served. Bill Hirsch said that they serve the whole Bay Area. They do not serve Santa Clara County, as there is a sister agency, AIDS Legal Services. There is an outreach attorney stationed three days a week in Alameda County. Housing work is much more focused on SF due to the renter protections provided in the SF Rent Ordinance. *AR* inquired about client demographics. They mirror what the demographic breakdown is in SF. Approximately 70% of clients make $15,000 or less annually.

LT asked if ALRP worked with clients who have criminal legal problems. ALRP does not provide criminal legal assistance. SF asked if ALRP provided assistance related to fair housing law outside of San Francisco. They do go to the surrounding counties and provide education for other agencies. *SF* asked if ALRP sought out affirmative suits. ALRP has very limited resources to do this. If there were additional resources available, *LT* asked ALRP what would be the most effective, cost efficient ways to improve housing for people with HIV. Bill Hirsch suggested the creation of more permanent housing with services, increase short-term rental assistance. *AC* thanked ALRP for their help in preventing clients, particularly those with subsidies, from being evicted.

Housing Wait List/CARE Subsidy Analysis – Flat Funding

Amy Cunninghis presented information sheets on the Housing Wait List and on the affect of flat funding with CARE subsidies. The average subsidy cost is $604; the total number of subsidy slots is approximately 320. Due to flat funding, as of March 1 the number of CARE subsidy slots was reduced by 12. Last year CARE subsidies would have lost the same 12 slots plus an additional 23 slots if the Board of Supervisors had not given one-time funding. Next year, if the Board of Supervisors does not give more funding, 35 CARE subsidy slots will be lost, which is approximately 10% of all available slots. The average cost of the partial rent subsidy is $365. The maximum allowed is $400. Each year the average amount of subsidy goes up causing another loss of slots. When the average subsidy is $400, 5 additional slots will be lost out of a total of 41 slots. *LT* suggested that the Council could help advocate for more funding by communicating the need to the Board of Supervisors.

SRO Task Force Update

Ann Kronenberg, DPH representative to the SRO Task Force gave an update of the work of the SRO Task Force. The Task Force got off to a slow start due the length of time it took for the Board of

Supervisors to officially put the task force in place. In the last year, the Task Force was broken down into the three sub-committees fire mitigation issues, prosecution and investigation issues, and families living in SROs. Each area is compiling a list of recommendations dealing with environmental health, living conditions, visitor fees (legislation is currently pending), sprinklers, elevators, residency (28-day rule), etc.

The Task Force is currently assessing what the city can do in the short term and long term. The Task Force does not want the set the priorities; they want the residents of SROs to determine the priorities. There is a hearing at the Board of Supervisors on May 15 before Social Policy and Economic Vitality at 10:00 a.m. The Task Force will make recommendations in three areas: legislative, policy, and budgetary. AK anticipates that the next year will be much more active for the SRO Task Force. There is perceived support from the Board of Supervisors. The SRO Task Force meetings are open to the public. They are held on the first Wednesday of the month in City Hall room 278, at 10:30 a.m. Public comment is held at the end of the meeting. Minutes are posted on the city's web site. MA encouraged members to attend the hearing on May 15.

Prioritization Update

BH informed the committee that at the next full Council meeting the Organizing Committee will present a proposal outlining meeting schedules, topics to be covered etc. He expressed the expectation that the Housing Committee will put together the presentation on housing for the Council prioritization process. Brad thanked Margot for her assistance in helping to plan the Housing Committee presentation.

Committee Co-chair Nominations

BH nominated Catherine G. for Co-chair, which she accepted. A vote will take place at the May meeting.

HIV Health Services Planning Council
Prioritization Organizing Committee

March Report – 3/21

Meeting Date:	Wednesday, March 21, 2001, 5:30 – 7:00 PM
Members Present:	Gary Harrell, PWA Caucus Co-Chair; Brad Hume, Housing Comm. Co-Chair; Jim Mitulski, Council Co-Chair; Greg Neumark, Membership Comm. Rep.; Susan Shea, I&E Comm. Co-Chair; and Bob Teague, Educational Rep.
Others Present:	Michelle Long Dixon, Laura Thomas, DPH; plus Steve Feeback, minutes and MJay Sanders, Consumer/Council nominee.
Next Meeting:	Thursday, March 29, 2001, 25 Van Ness, Room 330, 5:30 – 7:00 PM

Call to Order

Notes from Discussion

On the Role of this Work Group: The group discussed its mission, which was defined as putting together a proposal and a structure for how Priority Setting should go. Historically, the Prioritization process has been handled in a different way each time it has been done. The group will probably meet infrequently during the process, once it is underway. The group may also set up some guidelines for Presenters and issue requests for participation.

On the Methodology: Education is very important. AETC will provide background documents and educational materials for homework/study. AETC will also schedule orientation for newer members, with emphasis on Prioritization. Priority Setting is expected to be a process in which all Council members participate. Some committees have elected to continue with their regular meeting schedule for the time being, but it is hoped that members of those committees have the time to participate fully in Prioritization and contribute to this work. It is very crucial work for the Council, so all members should fully engage. The PWA Caucus has a key function of setting up mechanisms for consumer input into the process and being a channel for consumer needs.

On the Timeline: The group recommends that the Council meeting two times a month, starting April 9, in order to complete the Prioritization process by the end of August. Every part of the process will be accomplished in an orderly fashion by working backward from the August deadline. There will be time for evaluation at the end of the process.

On the Use of Council Meetings: Members need to hear from all service categories in order to be fully aware of the comprehensive service system. We need to give equal weight to each category. Council meeting time is also the appropriate time for getting clarification of issues and discussing the data in order to set the stage for constructive debate.

Adjournment
Jim Mitulski adjourned the meeting.

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SAN FRANCISCO HIV HEALTH SERVICES PLANNING COUNCIL
PRIORITIZATION 2002

***Ad Hoc* Organizing Committee Update**
March 26, 2001

The ad *hoc* Prioritization 2002 Organizing Committee met Wednesday, March 21, 2001 to begin preliminary planning for the Council's process of priority setting and resource allocation for fiscal year 2002.

In attendance:
S. Feeback; G. Harrell; B. Hume; M. Long Dixon (SFDPH HIV Health Services); J. Mitulski; G. Neumark; S. Shea; B. Teague; L. Thomas (SFDPH HIV Health Services)
(Refer to February 26 Council meeting minutes for details of ad hoc committee participation)

Committee Charge:
The ad *hoc* Organizing Committee's charge is to set a process and plan for the Council to accomplish its work on priority setting and resource allocation activities. These activities, which comprise the Council's primary mandated responsibility under the CARE Act, must be completed by early summer.

> **Priority setting is the responsibility of the entire planning body. While much of the preliminary work may be delegated to a committee, the planning body as a whole is expected to make final decisions about priorities and the resources allocated to them.**
>
> --from HRSA's *Priority Setting and Resource Allocation* Technical Assistance Manual

Current Process Proposals:
The ad *hoc* Organizing Committee makes the following preliminary process recommendations for consideration by the Council:

1. The HIV Health Services Planning Council meets twice monthly, beginning in April and continuing through July (April 9 & 23; May 7 & 21 [due to Memorial Day holiday]; June 11 & 25; July 9 & 23).

2. Standing Committees of the Council may elect to adjust/suspend their regular meeting schedules and work loads as appropriate, in order to focus on prioritization activities.

3. The Organizing Committee will present a complete Prioritization 2002 Process and Plan to the full Council at its meeting on Monday, April 23.

Next Steps:
The ad *hoc* Organizing Committee will meet two more times (Thursday, March 29 and Thursday, April 5; 5:30 to 7:00 p.m.; 25 Van Ness 3rd Floor Conference Room), to decide on the priority-setting structure and decision-making processes to be utilized for 2002 Prioritization.

HIV Health Services Planning Council
Prioritization Organizing Committee

March Report – 3/29

Meeting Date:	Thursday, March 29, 2001, 5:30 – 7:00 PM
Members Present:	Brad Hume, Housing Comm. Co-Chair; Jim Mitulski, Council Co-Chair; Greg Neumark, Membership Comm. Rep.; and Bob Teague, Educational Rep.
Others Present:	Celinda Cantu, Joseph Cecere, David Macias, and Laura Thomas, DPH; plus Steve Feeback, minutes and MJay Sanders, Consumer/Council nominee.
Next Meeting:	Thursday, April 5, 2001, 25 Van Ness, Room 330, 5:30 – 7:00 PM

Call to Order

Notes from Discussion

On the type of meetings we will be having during Prioritization: The General Meetings will become focused on Prioritization, but other business may be conducted, as needed. There will be a need for the training component to be included. We will have data presentations at each meeting. These need to be distributed throughout the process because we need to be aware of not overloading the members with more data than can be assimilated at one setting. Presentations will have to be well-planned. The Steering Committee will not be meeting before the Council meeting on April 9. Therefore, this work group is responsible for setting up the Council agenda.

Memo from Laura Thomas: Called Guidance on Priority Setting, this document deals with 1) Planning; 2) Process; 3) Decisions, as well as 4) Overall themes or goals. Laura has taken into consideration past experience as well as recent communications from HRSA following Reauthorization of the Ryan White CARE Act. She reviewed decisions already made by the Council such as "core vs. non-core services." She listed other documents that the Council has prepared such as the "Shared Values and Vision Statement" and the "severe need" definition. She said that HRSA has distributed some new requirements about "needs assessment activities." She discussed various types of "needs assessments." She proposed some ways of satisfying HRSA requirements, such as through focus groups or utilizing other data sources. Whatever is decided, these activities will have to come out of the Council Support budget, which was recently reduced. The group talked about various ways of defining "unmet need," taking into consideration HRSA requirements to assess the needs of people who know their (HIV+) status and yet are not in care.

Decision from Council Meeting on 3-26-01: The Council approved the idea of a twice-monthly meeting schedule and the general job description for this work group.

How to organize the schedule of data presentations: Laura acknowledged the difficulty of dividing the many service categories into groupings that would fit comfortably into approximately three presentations. Members lobbied for greater consideration of housing-related needs, including direct emergency assistance, eviction prevention, referral services and subsidies. Presentations will be coordinated by this work group. Presenters will likely include service providers and DPH staff. There was some discussion about coordinating the provider participation through the Provider's Network. This has to be coordinated with the training sessions. There is a need for a balance between philosophical information about services and factual data about the service system.

Planning Council Support Budget: Members questioned the use of funds during the past budget year, desiring to see a summary. This was felt to be important in allocating the budget for the upcoming year and the projects outlined in our Prioritization effort. Members called for an accounting of last year's

budget by line item so that it is understood what was spent and what was not spent. It was acknowledged that the Contractor, Positive Resource Center, was handed an already-developed budget last year and one that went through some revision. The Support budget includes Administrative work, Consumer Rights Advocacy work and other consulting. As part of Prioritization, what do we want for the future from this budget? This is the Council's budget and many members have a desire to be involved in deciding how it is used.

Group Process: Participation issues and training issues will be addressed because it is not yet clear to everyone how this Priority Setting business actually unfolds.

Adjournment

HIV Health Services Planning Council
Prioritization Organizing Committee

April Report – 4/5

Meeting Date:	Thursday, April 5, 2001, 5:30 – 7:00 PM
Members Present:	Gary Harrell, PWA Caucus Co-Chair; Brad Hume, Housing Comm. Co-Chair; Jim Mitulski, Council Co-Chair; Greg Neumark, Membership Comm. Rep.; Bob Teague, Educational Rep.; and Robert Whitford, PWA Caucus Representative.
Others Present:	Celinda Cantu, Joseph Cecere, David Macias, and Laura Thomas, DPH; plus Steve Feeback, minutes; Edward Paterson and MJay Sanders, Consumers/Council nominees.
Next Meeting:	Tuesday, April 17, 2001, 25 Van Ness, Room 330, 5:30 – 7:00 PM

Call to Order

Notes from Discussion

Laura Thomas and Bob Teague met to work out the details of a draft proposal. It was still sketchy, but members offered some questions and comments in order to flesh it out a bit more. The other theme of discussion in the work group was the need to go over basic plans about the Prioritization Process in the context of a Council meeting like that of April 9, in which there will not be other Council business to any significant degree. It will be an opportunity to go over the full game plan, even though some logistical points have already been decided and the CARE Act/HRSA has established some non-negotiable requirements. In the process of Priority Setting we have to consider certain characteristics of the epidemic and the interconnections of various services. So this Prioritization Organizing Committee has been delegated the task of planning the appropriate presentations that contribute to an orderly process. However, the group decided to have a full airing of the process, allowing all Council members the opportunity to express their viewpoints based upon a set of background documents, an overview of Priority Setting by Laura, and a detailed map of the process. Everyone should have the chance to talk about his or her expectations and to help formulate many of the details. Other business items were also noted, but were purposely limited to a single item: the nominations vote previously scheduled by the Membership Committee. Some parts of the overall Prioritization process, such as the Needs Assessment Activity, have budgetary implications. This prompted some of those present to ask questions about the current fiscal year Council Support budget. The DPH Program Manager for the Council Support contract was present, but he had not seen the draft budget being developed by the Contractor and one of the Council's Co-Chairs. A number of the Prioritization decisions depend upon budget allocations. It was decided to ask for a detailed budget no later than the April 23rd Council meeting.

Adjournment

Jim Mitulski adjourned the meeting.

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

May 7, 2001 4:30 PM

AGENDA

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I.	**Call to order**	4:30 PM
II.	**Roll Call**	4:32 PM
III.	**Review and Approval of Agenda**	4:34 PM
IV.	**Review and Approval of Minutes,** 4/09 — **VOTE**	4:36 PM
V.	**General Announcements**	4:39 PM
VI.	**Public Comment**	4:43 PM
VII.	**Reports**	
	• *Steering Committee Announcement about Co-Chair position (C. Geanuracos)*	4:49 PM
	• *Training, Bob Teague*	4:53 PM
	• *Needs Assessment*	5:20 PM
	- Presentation by Michael DeMayo, Harder +Co.	
VIII.	**Break**	5:45 PM
	• *Presentation on "Not in Care"*	5:55 PM
	- Panel: K. Clements, M. Crosby, C. Dawson Rose, M. Kushel, D. Robbins	
	• *Overview of New Federal Requirements*	6:45 PM
	• *Discussion on definition of "Not in Care"* — **VOTE**	6:50 PM
	• *Review of Prioritization Issues/Meeting Feedback*	7:15 PM
IX.	**New Business**	7:25 PM
X.	**Adjourn**	7:30 PM

Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Mon	5/14	Prioritization Organizing Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Wed	5/16	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	5/17	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	5/21	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	6/6	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	6/6	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	6/11	HIV Health Services Planning Council	City Hall	4:30 – 7:30 PM
Mon	6/25	HIV Health Services Planning Council	City Hall	4:30 – 7:30 PM

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PEOPLE LIVING WITH HIV/AIDS WHO ARE NOT IN CARE

Background

In October 2000, the Ryan White CARE Act was reauthorized for an additional five years. It was originally passed in 1990. This legislation provides significant funding for HIV health services. The San Francisco Eligible Metropolitan Area (San Francisco, San Mateo, and Marin) received over $36 million last year in Title I and II. Funds are prioritized and allocated through a community planning process overseen by the HIV Health Services Planning Council. The San Francisco Department of Public Health is the grantee and administers the contracts for services. Funds pay for the full continuum of services, including medical care, housing, substance abuse and mental health treatment, case management, and transportation.

In the new legislation, Congress added several requirements for data collection and program development, focusing on people living with HIV who are aware of their HIV status but are not accessing health care. Below is the excerpted legislative language from the CARE Act, with the most relevant parts in bold. The Planning Council is now responsible for determining the population size, demographics, and needs of those who are not in care, and then to develop a plan to address their needs.

From the Ryan White CARE Act Amendments of 2000:

(4) DUTIES.--The planning council established or designated under paragraph (1) shall-
"(A) **determine the size and demographics of the population of individuals with HIV disease**;
(B) **determine the needs of** such population, with particular attention to—
i)individuals with HIV disease who know their HIV status and are not receiving HIV-related services; and
ii)disparities in access and services among affected subpopulations and historically underserved communities;
(C) **establish priorities for the allocation of funds** within the eligible area, including how best to meet each such priority and additional factors that the grantee should consider in allocating funds under a grant based on the –
(i)**size and demographics of the population of individuals with HIV disease (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));**
(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;
(iii) priorities of the communities with HIV disease for whom the services are intended;
(iv) coordination in the provision of services to such individuals with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment for such abuse;

(v) availability of other governmental and non-governmental resources, including the State medicaid plan under title XIX of the Social Security Act and the State Children's health Insurance Program under title XXI of such Act to cover health care costs of eligible individuals and families with HIV disease; and
(vi) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities;

D) **develop a comprehensive plan** for the organization and delivery of health and support services described in section 2604 **that –**

(i)**includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities**, and including discrete goals, a timetable, and an appropriate allocation of funds;

ii)includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse); and

iii)is compatible with any State or local plan for the provision of services to individuals with HIV disease;

Additional references to PLWH not in care include the definition of "severe need". Severe need counts for 33% of the points in our competitive grant proposal for CARE funds. The ability to document the extent of the need will help us be more successful in bringing in funds for services.

(B) SEVERE NEED.--In determining severe need in accordance with paragraph (1)(B), the Secretary shall consider the ability of the qualified applicant to expend funds efficiently and the impact of relevant factors on the cost and complexity of delivering health CARE and support services to individuals with HIV disease in the eligible area, including factors such as--

(i) sexually transmitted diseases, substance abuse, tuberculosis, severe mental illness, or other co-morbid factors determined relevant by the Secretary ;

(ii) new or growing subpopulations of individuals with HIV disease;

(iii) homelessness;

(iv) the current prevalence of HIV disease;

(v) an increasing need for HIV-related services, including relative rates of increase in the number of cases of HIV disease; and

(vi) **unmet need for such services, as determined under section 2602(b)(4).**

Outreach to this population is now fundable under the new legislation. The following has been added to the list of fundable services.

(D) **Outreach activities that are intended to identify individuals with HIV disease who know their HIV status and are not receiving HIV-related services** and that are---
i)necessary to implement the strategy under section 2602(b)(4)(D), including activities facilitating the access of such individuals to HIV-related primary care services at entities described in paragraph (3)(A);
ii)conducted in a manner consistent with the requirements under sections 2605(a)(3) and 2651(b)(2); and
iii)supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.

Questions to be answered

There are multiple studies currently in progress that include people living with HIV who are not in care. Some are focused primarily on health care access, and others include it as a secondary issue. Here are some of the questions we need answers to. Some may be easy to answer and others may be more difficult.

Research:

- What studies are currently being conducted in San Francisco that include people with HIV who are not in care (study population, methodology, timeframe, etc.)?
- What questions are being asked and what data is available so far?
- Is there additional analysis of existing data that could be done?
- What would that cost?
- Are there other sub-populations that are not included or need to be studied more closely?

Big Questions:

- How many people living with HIV in San Francisco know their HIV status and are not in care?
- What are their demographics (race, gender, age, transmission risk, neighborhood, etc.)
- What are the various levels of "not in care"?
- Are these folks accessing any other services?
- Why are they not in care?
- What would bring them in to care?

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Minutes, May 7, 2001 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at next meeting

I. Call to Order
4:40 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
Stephan Oxendine reviewed the agenda, and it was approved.

IV. Review and Approval of Minutes
4/9/01 Council Meeting Minutes – no corrections were requested. It was moved to adopt the Minutes. By voice vote, the Council Meeting Minutes were approved. Two members abstained.

V. General Announcements
Toni Butler distributed a copy of the California STD Controllers Association guidelines on the treatment of people with HIV. It is designed for providers and patients in order to help them ask better questions about the interaction of HIV and other STDs. *Gene Gowdey* announced that a formal grievance had been filed with DPH in regards to a Review Panel Process. He said that the grievance affects the Planning Council because it involves the AIDS Office not following the guidelines that were set down in the last prioritization process.

VI. Public Comment
David Bush, a 16-year veteran of AIDS lived in a home sponsored by the Arc of Refuge Church in Oakland. When the lease expired this year, the house closed. He was asking the Planning Council for suggestions to his housing crisis.

VII. Reports

VIII. Steering Committee
SO announced that the election for a new Co-Chair would take place at the June 11 Council meeting. Catherine Geanuracos had agreed to stand for election to the post.

IX. Prioritization Process Training
Bob Teague passed around several training materials. He announced that new member orientation would be taking place and that his office would be mailing additional information to back-up some of the other training modules. The Training for this meeting centered on "Understanding the System of Care." *Russ Zellers* passed around a spreadsheet containing the full Health Services budget for FY01. It reflects the full system of care and includes numerous funding sources. A vote on this budget was scheduled for the next Council meeting.

X. Needs Assessment
Michael DeMayo, a representative from Harder +Company (an independent social science research company that conducted the last Needs Assessment in 1999-2000), provided an overview of met, unmet, and unsatisfied needs within the ten service categories that the Council had recommended be researched: 1) Primary Medical Care, 2) Case Management, 3) Dental Care, 4) Housing, 5) Food Assistance, 6) Mental health Services, 7) Transportation, 8) Substance Abuse Services, 9) Complementary Treatments, and 10) Home Health Care. *Michael* stated that copies of the final report of the Needs Assessment are available through the AIDS Office. He indicated that the survey tried very hard to sample in a wide cross section of locations. Still, only a very small number of respondents

could be defined as Not In Care. He went on to say that the Council needed to have a clearer picture of those that they perceived to be out of care. The overall sample consisted of 1,280 people living with HIV/AIDS in San Francisco and San Mateo counties. The subjects were 74% Male, 18% Female, and 8% Transgender. The ethnic distribution of the sample was 44% African American, 38% White, 12% Latinos, 4% Asian/Pacific Islanders, and 2% Native American. He indicated that the largest portion of the sample was between the ages of thirty and fifty. He presented a breakdown of the sample by mode of exposure as well, with 33% being gay men, 25% being IDU, and 13% MSM-IDU. The full report also contains breakdowns by housing situation, insurance, health indicators, it shows that 56% had received an AIDS diagnosis while 44% were HIV-positive not diagnosed with AIDS. He showed a rank order listing of service categories by perceived need. The rates of unsatisfied need were relatively low in all service categories, with dental care being the most significant. He said the report indicated that there were similar unmet needs across racial and gender lines, with housing, dental care and home health care consistently being the service categories where there was the greatest unmet need. But, African Americans and Native Americans reported the highest unmet needs for many services.

Michael presented several key findings. Survey results were analyzed by race/ethnicity, gender, housing status, county of residence and transmission group. Almost all population groups identified primary care as their top need, and the vast majority reported it as a met need. Other findings: 55% of those surveyed said they were taking HIV/AIDS medications (the survey only asked about antiretrovirals and protease inhibitors) 65% of people with an AIDS diagnosis were taking medications, and 37% of the homeless or marginally housed were taking medications. Transgender people had the lowest percentage of those taking medications (52%) followed by females (55%) and then males (57%). African Americans made up the highest percentage of the people who were homeless or marginally housed at the time of the survey (nearly 50%). Levels of homelessness were also higher among females and transgender than among males. Levels of homelessness were also high among youth and IDUs. Homeless and marginally housed PLWH reported higher levels of unmet need for medical care, dental care, case management and substance abuse services. They are also less likely to be taking medications: 63% of the homeless people were not taking meds compared to 41% of PLWH who had stable housing. Unstable living situation was the strongest indicator for never taking HIV-related medications and for poor adherence habits.

The survey over sampled African-Americans because the Council requested such a sampling design. The current system measures perceived unmet need. This is only one measure of unmet need and may reflect a lack of system capacity or availability of services, or could reflect a number of barriers such as lack of knowledge, poor distribution of resources, lack of access, or poor quality of service. The measure of unmet need was determined by client perception. He recommended a more objective basis for measuring unmet need in future surveys or utilization of a broader definition. He reviewed different types of need (perceived need is the type used in the survey) and different methods for measuring unmet need.

XI. Break

XII. Reports: Not In Care

Laura Thomas prefaced the topic of discussion by saying that the invited speakers are researchers or other people involved with programs that have contact with people who know their HIV+ status and are not in care. She also referred to the language contained in the Reauthorized Ryan White CARE Act and its mandate to determine who the people are who are not in care and to develop programs/services that bring them into care.

The first of the presenters in this area was Carol Dawson Rose. Her research is about current injection drug users who have an opposite sex partner. The San Francisco area segment of her study is small, 79

people, but that portion is not significantly different from the make-up of the overall sample. The study contained a survey and a qualitative interview. The purpose of the study was to focus on sexual habits that related to HIV transmission. The information which can be gleaned from the study on the topic of access to primary care is minimal. A high percentage (97%) said they do have a primary health provider that they go to for HIV medical care, while 91% said they had a viral load/CD4 count taken in the past six months and 47% of the sample were taking HAART. All but one respondent was using IV drugs at the time they were tested for HIV infection. One person started using after finding out about his HIV status. Many went through periods of wanting to drop out of everything. Their access to care was also subject to spurts of on then off. Many in the study have a history of bad encounters with care providers. They felt as though they were not treated with respect, they were seen to be lying, they were less than ideal patients, they were not timely about appointments, etc. These experiences added up to a lack of trust in their providers. Many in the study identified their drug use as a barrier to care. Some felt they were not ready for HAART as a method of dealing with their HIV disease. They view themselves as trying to manage their drug use while coping with HIV disease as another problem in their lives. The same research group is starting an intervention study as well, trying to get current injection drug users into regular care (CD4/viral load checks every 3 months approximately) as opposed to sporadic care. They want to look closely at the problems with access to care.

XII. Reports: Not In Care (continued)

SO called upon David Bainsberg to present the next part of this report. He introduced himself as a primary care physician at Ward 86 dealing mainly with HIV disease. His research involves people who are homeless or marginally housed and having HIV infection. He and Andrew Moss are studying how this population accesses health care, how they adhere to HIV medications, and what happens to their virus and their health status as they either adhere or don't adhere to their medications. They recruit for their study at the lines of people waiting for free lunch programs, the homeless shelters and a range of the SRO hotels in San Francisco. HIV testing is offered on a Monday, with an interview, for a $15 reimbursement, asking people to come back for the test results. Those who are found to be HIV+ are enrolled in a prospective cohort, called REACH. It started back in 1996 and 97. The researchers are interested in the residents of low-income hotels in San Francisco (mostly the Mission, SOMA and the Tenderloin). There are 19,000+ people living in these hotel rooms, with an 80% occupancy rate and about 36% living with at least one roommate—total is thus about 21,000 people. About 80% of them have been homeless at some time in the past; about 30% are homeless every month. This is believed to be the core of the homeless population because they are constantly at risk for being homeless. Those seen on the street (about 5,000 people) are just the tip of the iceberg. Up through the year 2000, they had administered the HIV test to over 4,000 people, with 9% of the people living in these conditions are HIV infected. The cohort is made up of the 87% of these people, who returned for their results and agreed to be in the study. Dual risk factors make the group of MSM who inject drugs the highest percentage in the cohort, with 29%. In terms of gender, 84% are males, 9% are MTF Transgenders, and 7% are females. Over half the study is people of color. There is a distribution among risk factors. They are pleased with how well they have been able to keep track of people and retain them in the study. Over 90% are still involved. This can be attributed to the local site operating within the low-income neighborhoods, as well as to the incentives. They also have a mobile tracking staff, assigned to go out looking for people. Within the cohort, 25% don't have a primary care provider, while 23% use SF General Hospital, 33% use the community clinics, 18% use private practice providers and 1% at the Veterans Affairs Hospital. Most people brought into the study had known beforehand that they were HIV+ and 78% had been tested someplace else. The median time of having an identified primary care provider is 29 months, and they see that person seven times a year (nine total medical visits, including specialty care). So, the three-fourths who can identify their provider are pretty similar to any HIV+ population in that they go about every other month and have been doing so for more than two years. This is a stable pattern of utilization. About 50% of the cohort are receiving HAART. He estimated that about 60% are covered by MediCal. Over half of those in the study have gone to the ER in the past

12 months, but only 10-20% are frequent users of the ER (about half the visits are HIV-related & half not, with drugs and psychiatric reasons being the highest other factors). Similarly, half the mortality in this population is due to AIDS and half the deaths are related to other causes (mainly hepatitis and liver failure). David was not able to develop any statistical characteristics of the roughly 25% who are not receiving care. This is something they will be working on.

Diane Robbins introduced herself as a Nurse Practitioner with DPH and the primary provider on a mobile health van called Neighborhood Health on Wheels. The van is part of a 5-year demonstration project. The van has been providing services since August 2000. They have not found many people previously untested or many new HIV+ people. She reported a wide variety of primary care history among the patients who disclose their status and talk about their experience. She reported the schedule of their expanded services in the Castro and in other parts of the city in connection with Needle Exchange. In addition to HIV testing, they do screening for other STDs and vaccinations for hepatitis A & B. They also provide some urgent care, such as treatment of abscesses. Hep-C testing and counseling is apparently centralized at SF General.

XII. Reports: Not In Care (continued)

Kristen Clements, from the Department of Public Health AIDS Office, presented data on the Transgender Community Health Project. Eligibility for the study required that participants be male-to-female or female-to-male transgenders, 18 years of age or older and had either lived, worked, or socialized in San Francisco within the prior six months. She noted that 85% of the participants lived in San Francisco. The recruitment for the study took place from July 1st to December 31st, 1997. Targeted recruitment was in bars and clubs, then through referrals with incentives. They had an initial sampling of 585 people, then 515 people completed the first phase of interviews and testing for HIV: 392 MTF and 123 FTM. The male to female population was where they found the majority of the HIV disease. The median age was 34 years. No one group was over sampled. 32% were born outside of the United States mostly from Latin American countries and Southeast Asian countries. 55% had a history of incarceration, 31% had been incarcerated in the past year prior to the study. They had a median monthly income of $744. 50% were not insured either publicly or privately. 34% had public insurance and 14% had some kind of private health insurance. 29% had less than a high school education. 27% lived in SRO hotels. 13% were currently homeless. 7% were crashing with someone. Unstable housing conditions tended to be the norm for the participants. 35% of the sample were HIV+. 20% found out they were HIV+ for the first time through the study. 89-91% had tested prior to the study but there was an inconsistency. 65% already knew their HIV status prior to the getting the results of this test. Of those 89 individuals, 20 of them, or 22% were not currently receiving any medical care for HIV.

KC found that despite the small numbers, she analyzed the 20 MTF transgenders who knew they were HIV+ but were not in care. Some statistical characteristics were worth pointing out: if you look at people of color among this group, 24% were not in care compared to 13% of white participants; if you look at housing, 32% of those living in unstable housing (classified as shelters, SROs, and the street) were not currently receiving HIV care compared to 15% living in stable housing (classified as paying rent in their own apartment or living with a friend in the past six months); if you look at insurance, 35% of the uninsured were not receiving primary care compared to 18% of the insured; and if you look at current sex work, 27% are not currently in care. This information is from 1997, but she understands that current conditions are much the same for this population. It is a non-random sampling, but the only option for such a first-time study.

Recommendations. Kristen said that about one-third of the MTF transgenders did not know they were HIV+ before taking the test as part of their study. Access to testing is important for this population. It is a way of getting them into care. Among HIV+ MTF transgenders, 20% were not in care. Outreach

to SROs and street bar locations is necessary to reach this population. Only with that outreach can these individuals not in care be found and encouraged to seek care. Perhaps medical care for HIV could be combined with hormone therapy. Hormones are currently available from clinics, but also as street drugs. This population may come in the door for hormones, then be drawn into HIV care as a natural process. She was asked about the FTM transgenders (n=123). Of these, two were HIV+, a rate of 2%. Both individuals knew their status and were in care. She responded to another question saying that needle sharing for hormone use is extremely rare among transgenders. Street drugs (speed) are a different story. There are four clinics dispensing hormones and clean syringes. So the risk of transmitting HIV by sharing needles is overwhelmingly because of street drugs, not hormone therapy. The sampling for this study was done in the Tenderloin, SOMA and the Mission. Laura Thomas offered to send out copies of Kristen's overall study, but this report tonight was more focused on the Not in Care issue.

XIII. A Working Definition for those Not In Care

SO called for the formation of a committee to create a working definition to describe those not in care. *MJay Sanders, Mark Dunlop, and Rob Whitford* volunteered. *Laura Thomas* presented the specific language of the Ryan White CARE Act about there now being an additional responsibility of the Planning Council: to determine the needs of those people who know their status yet are not in care and to develop programs intended to bring them into care. She said that it was imperative for the Council to have a definition of "not in care." She thanked the working group of volunteers.

XIV. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

May 7, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P									
2. Hazel Betsey	*HB*										
3. Toni Butler	*TB*	P									
4. Jeff Byers	*JB*	P									
5. Bart Casimir	*BC*										
6. Cecilia Chung	*CC*	P									
7. Raymond Combs	*RC*										
8. John Conley	*JC*	P									
9. Mark Dunlop	*MD*	P									
10. Gregory Edwards	*GE*	P									
11. Donald Frazier	*DF*	P									
12. Catherine Geanuracos	*CG*	P									
13. Fernando Gomez-Benitez	*FGB*	P									
14. Gene Gowdey	*GG*	P									
15. Gary Harrell	*GH*	P									
16. Brad Hume	*BH*	P									
17. Sam Kaplan	*SK*	P									
18. Gene London	*GL*	P									
19. Carmen Madríz	*CM*	P									
20. Michael Meehan	*MM*	L									
21. Allen Meyer	*AM*	P									
22. Jim Mitulski	*JM*	P									
23. Gregory Neumark	*GN*										
24. Stephan Oxendine	*SO*	P									
25. Wayne Peace	*WP*	P									
26. Ken Pearce	*KP*										
27. Alissa Riker	*AR*	P									
28. Susan Shea	*SS*										
29. Janis Takamoto	*JT*	P									
30. Bob Teague	*BT*	P									
31. Jose Villarce	*JV*										
32. Robert Whitford	*RW*	P									
33. Mary Jane Wood	*MJW*	P									
34. Karen Wuopio	*KW*	P									

MEMO

DATE: *June 1, 2001*
TO: *HIV Health Services Planning Council*
FROM: *"Not in Care" Ad Hoc Work Group*
RE: *Proposed Definition*

Proposal:

For the purposes of needs assessment, priority setting, program design, comprehensive planning, and other Council activities, "not in care" or "not receiving HIV-related services" is defined as:

> **People living with HIV who know their HIV status and have not seen a clinician for HIV-related medical care in more than six months.**

This definition is inclusive of those who:

- have never accessed any kind of medical care or HIV-related service since testing HIV positive,
- have accessed some social services but not medical care,
- have accessed some services including medical care in the past but are not currently getting any care or services, and
- are getting some social services but haven't been to a clinician in more than six months.

Consistent with the federal legislation and guidance from HRSA, this applies only to people who are HIV positive, have been tested, and know that they are positive.

Background:

A definition is required to implement the reauthorized legislation. In the reauthorized Ryan White CARE Act, Congress added several requirements for data collection and program development, focusing on people living with HIV who are aware of their HIV status but are not accessing health care. Below is some of the excerpted legislative language from the CARE Act, with the most relevant parts in bold. The Planning Council is now responsible for determining the population size, demographics, and needs of those who are not in care, and then for developing a plan to address their needs.

> (4) DUTIES.--The planning council established or designated under paragraph (1) shall-
> "(A) determine the size and demographics of the population of individuals with HIV disease;
> (B) **determine the needs of** such population, with particular attention to—
> i)**individuals with HIV disease who know their HIV status and are not receiving HIV-related services**; and
> ii)disparities in access and services among affected subpopulations and historically underserved communities;

Rationale:

The Council needs to develop its own definition. HRSA has not yet provided specific guidance on the issue, other than a requirement to do a supplementary needs assessment for people who are not in care. HRSA has issued a summary of a meeting it held last fall on the issue. One of the first recommendations from that summary is to develop a consistent definition of "not in care." The meeting summary list some of the definitions used in various places and contexts, but does not offer one recommended definition.

To conduct its business, the Council needs a clear and agreed-upon definition. The problem with a vague definition is that different people mean different things when they talk about folks who are not in care. In order to understand the demographics and needs of a population, it is necessary to know what the parameters of that population are, or in other words, who is in that group and who is not in that group.

The work group decided that the definition should include people who:

- Have never accessed any kind of medical care or HIV-related service since testing HIV positive
- Have accessed some social services but not medical care, and
- Have accessed some services including medical care but are not currently getting any care or services, and haven't been to a clinician in more than six months.

The work group felt that the six month time frame was an appropriate middle ground. They considered longer time frames, such as a year, and shorter ones, such as three months. Six months also represents the maximum amount of time one should go between CD4 counts, according to the Public Health Service guidelines for HIV care. This definition *excludes* those who are getting services including medical care but are not consistently seeing a clinician for medical care as long as they have been to a clinic within the last six months. It would also exclude those who may be going to ER for medical care but do not have a regular clinician.

Process

At the May 7th Council meeting, the Council heard several presentations on the topic of people with HIV who are not in care. At the end of the meeting, the co-chairs requested that a work group form to develop a definition of "not in care" and bring it back to the full Council for a vote. On May 22nd the work group convened and developed the definition above. They discussed potential definitions and their implications. There was unanimous agreement on this definition.

Present at the meeting were Council members Mark Dunlop, Rob Whitford, Bob Teague, and MJay Saunders, and AIDS Office staffer Laura Thomas.

HIV Health Services Planning Council
Conflict of Interest Disclosure Form

"In order to avoid the appearance of conflict of interest in the course of Council meetings or activities, Council members shall sign a written statement agreeing to voluntarily disclose any interests in a transaction or decision where the member; member's family, including domestic partners; employer; or business affiliation, including board membership, will receive a benefit or gain. Council members should provide open disclosure and description of potential conflicts, and abstain from voting in the event of an actual conflict as determined by the Council." – Council By-laws

Please list all agencies or organizations with which you have been affiliated in the last three years which have received Ryan White CARE Act Title I funds in the San Francisco EMA or could apply for such funds in the forseeable future. Include employment, consulting, board memberships, employment of family members and partners, or any other relationship which could appear to cause a conflict of interest.

Agency	Nature of Affiliation

Signature Date

03/16/00

122
-1
5/21/01

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

May 21, 2001 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes**, 4/23 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:39 PM**
VI.	**Public Comment**	**4:43 PM**
VII.	**Reports**	
	• *Steering Committee*	**4:50 PM**
	- Planning Council Support Budget — **VOTE**	
	- Full FY01 Budget — **VOTE**	
	• *San Mateo County Report*	**5:20 PM**
VIII.	**Break**	**5:40 PM**
	• *Presentation on Primary Medical Care*	**5:50 PM**
	• *Presentation on Dental Care*	**6:20 PM**
	• *Presentation on Complementary Care*	**6:30 PM**
	• *Presentation on Home Health Care Services*	**6:45 PM**
	• *Discussion/Meeting Feedback*	**7:00 PM**
IX.	**New Business**	**7:25 PM**
X.	**Adjourn**	**7:30 PM**

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Wed	5/23	Prioritization Organizing Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Thurs	5/24	New Member Orientation	1855 Folsom St. Rm. 126	2:00 – 6:00 PM
Wed	6/6	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	6/6	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	6/11	HIV Health Services Planning Council	City Hall, Room 34 (basement)	4:30 – 7:30 PM
Thurs	6/21	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	6/25	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	7/4	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	7/4	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	7/9	HIV Health Services Planning Council	City Hall	4:30 – 7:30 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

Minutes and Meeting Reports will follow in a separate mailing.

Steve

Minutes, May 21, 2001 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at next meeting

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I. Call to Order
4:40 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda was reviewed and approved.

IV. Review and Approval of Minutes
4/23/01 Council Meeting Minutes – no corrections were requested. It was moved to adopt the Minutes. By voice vote, the Council Meeting Minutes were approved. Two members abstained.

V. General Announcements
Mark Dunlop, who is working on the definition of "Not-in-care," announced a work group meeting. *Jim Mitulski* announced a presentation by Amber Hollibaugh on HIV prevention for women. **Proxy forms** were announced: *Greg Edwards* appointed *Stephan Oxendine* to be his proxy voter. *Greg Neumark* appointed *Robert Whitford* to be his proxy voter.

VI. Public Comment
A large number of people from the public attended the meeting. A major topic of concern was dental care and the availability of quality services for people living with HIV and AIDS. *Lucky Choi* spoke about the care he had received in the past and stated that he felt that dental care should be decentralized. He felt that recent decisions involving community-based dental care had not taken into consideration the clients that receive the services. *Brian Vouglas* spoke next and stated that he was there to put his voice into the decision-making about dental care services. *Rick Manring* stated that receiving service from the dental school was frustrating and resulted in long waits for appointments and problems with service. *Michael Meehan* echoed these complaints. *Curtis Turpeau* felt that he had been discriminated against by a housing agency because he uses medicinal marijuana. He has been kept out of a housing opportunity and is therefore forced to remain in his current situation of emergency shelter.

VII. Reports
VIII. San Mateo County
John Conley gave a prioritization report for San Mateo County. He spoke about how the HIV epidemic in San Mateo is similar to the epidemic in San Francisco and also how it differs. An example of the differences that he gave was how a host of contractors in San Francisco will respond to available dollars as compared to very few contractors in San Mateo that will respond to available dollars there. *JC* stated that the political position that the fight against HIV holds in San Francisco is not part of the political landscape in San Mateo County. If a cut to Title I funding was to hit the San Mateo service system, he said it would be an uphill battle to get any of that funding restored out of the County health budget. There are very few visible and vocal proponents for HIV-related issues.

He highlighted how the impact of AIDS has also differed from San Francisco by offering these findings: AIDS cases in the County since 1981 equal 1,889. Living AIDS cases are 712. San Mateo County Health Department HIV services see 554 clients per year. Emergency Financial Assistance was extended to 126 clients. The Food Program served 238 clients. Community dental care serves 85 people. Residential services served 184 clients. Substance abuse treatment (which includes detox, inpatient and outpatient services) is provided by about 15-20 different agencies on a fee-for-service basis. San Mateo County services for people with HIV include substance abuse treatment on demand.

Gender distribution of cumulative AIDS cases was 88% male to 12% female. In living AIDS cases, the ration is 84% male and 16% female. In the County's primary care services, the ration is 73% male and 27% female. In food services, the ratio is 58% male and 42% female. Higher percentages of women with HIV utilize the funded services than the men. There was a similar pattern based on racial/ethnic distribution. While 64% of cumulative AIDS cases and 58% of living AIDS cases were among Whites, they make up 37% of those using the County's primary care services. African Americans make up 18% of cumulative and 21% of living AIDS cases compared to their percentage of 34% of the clients in the County primary care program and 50% of clients in the food program. African Americans make up just 5% of the County's population. There is a vastly disproportionate impact, as shown by the AIDS case rates by race and year of diagnosis, on the African American community. The geographic distribution is that the northern part of the County (Daly City & South San Francisco) is where PLWH are mainly gay men, while the southern part (East Palo Alto primarily) is where there are higher numbers of injection drug users and their heterosexual partners.

Mary Jane Wood compiled survey response information for San Mateo County's AIDS program. She said that San Mateo County is unique in that their prevention services and care services are very highly integrated. The survey is for the entire AIDS program of the County. When someone tests positive on one of their mobile testing vans, a health outreach worker is on the van at the time of the testing. Should they choose, the person has the option of seeing the outreach worker right then and there. It is the responsibility of the outreach worker to enroll that client into housing and food programs, substance abuse counselors, and establish a primary care plan. *JC* stated that the health outreach team is another cornerstone of the AIDS program that they are proud of. Primary care services and ancillary health services are centralized, so transportation services are necessary to get clients to their appointments.

In closing, *JC* invited all Council members to come to San Mateo and see their services first hand. He clarified an earlier point that San Mateo has only in home hospice services and no residential care facilities. They are working on a plan where a person with AIDS from their county can be admitted to a hospice in San Francisco and paid for through HOPWA dollars. The Mental Health Association is their housing provider and the residential services are varied—shallow rent subsidies are one example. The county currently places HIV clients in non-HIV specific housing. He stated that housing is a major problem in the county and that San Mateo has lost more clients to its housing crisis than to HIV/AIDS itself because they couldn't find section 8 housing or if they did, they are subject to sudden landlord evictions. There is no form of rent control in San Mateo County and rental housing is decreasing.

IX. Dental Care presentation

Beginning in 1998 the Planning Council allocated funds for decentralized dental services based on needs assessment data from clients and public testimony. Prior to this time, Ryan White CARE funds were utilized only for centralized dental care at a University dental school in San Francisco. *Celinda Cantu* from the AIDS office gave a break down of the Dental Care Budget: $1,194,928. This figure represents 11% of the overall health care sub-category, 3.5% of the overall CARE budget, and 2.8% of the overall HIV Health Services continuum. Centralized care is what she referred to as "one stop shopping" where a consumer can access all of their medical needs in one location. De-Centralized service means that multiple locations are available. Her budget shows that Title 1 funds were split almost evenly between the two modes of Dental Care services with De-Centralized receiving more slightly more funding than Centralized, which appears to be more cost effective. Dental Services UOS by Percentage, showed the target and actual units of service were achieved, (a unit = an encounter), between Centralized and De-Centralized Dental Services. She said that one current aspect of the dental care funding picture is the partial dental reimbursement that can be gained from CARE Title F and from ALFA. Another current project has to do with standards of care for dental services. Overall, the main goal of dental care is to eliminate dental infections, pain and discomfort, improve general health and well being, and minimize side-effects of medications.

Charlene Pugh from UOP Dental School spoke next. In May of 2000 the Surgeon General came out with a report that found that 14% of people within the HIV community had unmet dental needs. This was 5% more than the general population in previous studies. Bad oral health for PLWH reduces quality of life because some people lose the ability to chew food. Oral health services are an integral part of the continuum of care that must be provided for those infected with HIV/AIDS and a special effort has to be made in outreach to people of color. Both Centralized (offers a variety of dental practitioners under one roof) and De-Centralized (offers care at multiple service sites) dental services are equally concerned about the standards of care that they provide. *Rob Whitford* addressed the many complaints that have surfaced concerning quality of care at the Dental School CARE Program. Charlene Pugh responded that UOP Dental School is trying to counter the lengthy amount of time that some patients have to wait in order to have their dental work completed and the seeming lack of sensitivity towards the patient.

Gene Gowdey objected that the Prioritization process was not considering the possibility that the previously approved division of dental services between Centralized and De-Centralized alternatives is not being implemented properly in the current year. *Jim Mitulski* cut him off because he was not presenting information about dental care or service. A member of the public objected to policies about missed dental appointments. *Margot Antonetty* asked for clarification surrounding the differences between Centralized and De-Centralized services. *Charlene Pugh* stated that there was probably not much difference in the service, but there was a need to provide alternative locations and some variation of procedures. The differences and the locations are outlined to the consumers and they pick which will be most effective for them. She asserted that both Centralized and De-Centralized services strive for the highest quality standard of care.

Julian Ponce, UCSF Dental School Dean, commented that he knew that there existed a lot of community concern over the awarding of dental contracts and he wanted to share his perspective and offered to answer any questions that people may have. He confessed that the clinics where pre-doctoral students practice are somewhat slower in service than those that have regular dental practitioners. He also said that some clinics where slower in rendering some of their services because of the populations that they served and the teaching techniques for special populations. Comments came from the public about needing an alternative to "assembly-line style" care in the dental schools. Someone asserted that one appointment in the De-Centralized location could equal the amount of work accomplished in four or five appointments at the Centralized locations. He also commented on the high amount of noise pollution in the environment of the Dental School facilities, with lots of people and machinery in one large space. He called for more one-on-one contact between client and dentist. *Ali Riker* asked for clarification about the process and whether the controversy was due to a programmatic issue that the Council would need to examine. *Michele Long-Dixon* replied that since the former Contractor had threatened legal action due to a grievance about the Review Panel process, she had been advised not to comment on any matters related to the process for selection of a Contractor. She commented later that the change of contractors is a change that will result in a facility located in the Tenderloin neighborhood, where a large number of consumers live.

Larry Cruz asked to clarify that dental services are contracted to the dental schools, and the role of dentists in providing the actual patient care. *Celinda Cantu* replied that the DPH is also a service provider in this category, so not all the dental services are contracted to the dental schools. The care provided at the schools by student dentists is monitored by dental faculty who are dentists themselves. Specialists are also available to patients receiving care at the dental schools. The DPH facility is staffed by licensed dentists, and patients have the option of going to that dental clinic. *Jim Illig* asked the dental providers present (and by extension other providers speaking later about other service categories) to address how they assure that the patients they see don't have other insurance, such as MediCal. *Dan Vuic,* from UOP CARE program, said that they were recently equipped to go online to access MediCal

information. Upon intake, clients are asked about MediCal and private insurance, in order to assist in developing their treatment plan.

X. Break

XI. Steering Committee Report

Stephan Oxendine called for consideration of the Council Support budget leading up to a vote. *Gary Harrell* introduced an amendment that had been forwarded to the Council by the PWA Caucus. He said that the rates to be paid to consultants were too high in this budget. Monies saved from lowering consultant fees could be reallocated to hiring outreach consultants and to producing outreach materials. Also, reallocated funds would be applied to the salaries of the Administrative Coordinator and the Administrative Assistant. The amendment was passed by the PWA Caucus on a vote of 3 to 1. In support of the amendment, *Greg Neumark* read a provision from the Ryan White CARE Act, which said that Planning Council support includes "reasonable and necessary marketing activities associated with publicizing the Planning Council's work and programs for the HIV infected population and sub-populations, which enhance community participation in the Planning Council." He went on to say that it is the responsibility of the Council as mandated by the CARE Act to increase outreach efforts and to increase membership from among unaffiliated consumers and historically under-served populations. He felt that not enough support for such activity was currently included in the budget. Greg complained that the Council last year spent less than half of the money it had budgeted for materials and did not expend $41,000 of its total budget. He said he would have brought this proposal sooner had he known that there was going to be money left on the table at the end of the fiscal year. He said that since that opportunity for funding the Council's outreach efforts was lost, he had to look for money to move from some other line item. He chose consultants fees to reduce, feeling that $100 per hour was too high.

Michele Long Dixon said she felt this amendment went beyond the Council establishing a budget to fulfill its scope of work and came close to dictating the terms of a contract. The Council doesn't have authority over contractual documents, and this budget is a contract exhibit that is close to certification. A query was raised as to the validity of the Council making fiscal decisions for the Grantee, DPH. In response, *GN* quoted from the Ryan White CARE Manual stating that, "while the Planning Council may not select particular entities to receive CARE Act funding, it may be involved with selecting particular entities and people to carry out activities directly related to Planning Council functioning and responsibilities." He said that the Council, in his opinion, does have the power to change line items and budgeted amounts. He wanted this process of approving the Council Support budget to be accountable to the Council. *MJW* clarified the amount for salary to the Consumer Rights Advocate and asked for a rationale to increase staff salaries, which *GN* provided. *Fernando Gomez-Benitez* said he supported the amendment, but had some doubts about under-funding the projects on which the Council needs consultants. *Brad Hume* asked if the people doing the outreach work would be Council members? *GN* answered that he hoped Positive Resource Center would find Council members and others who could do this type of outreach for the Council. *SO* said there was no assurance that PRC would accept this change in the budget or would do this work. *CG* said an alternate option was just to reduce the Consultants line items, then the decision could be made by the Contractor whether to accomplish this by a reduction in hours or in rate of compensation. *Mjay Sanders* said that the Council had learned very late in the process that there was $41,000 that was left unspent last year. It may be too late to spend that money, but it will help in the current year to have a budget that is more consistent with the Council's plans. To him, it didn't change the overall budget picture to adjust line items. *SO* replied that it was a change in the scope of work in the contract. *MLD* didn't want to get into a position where no one wanted to do this work and the contract had to be put out in another RFP. *Joseph Cecere,* from DPH, said the original budget for this contract had been approved in a vote of the POC/Steering Committee. He said the Contractor would try to negotiate the best rate. The amendment was re-phrased by *AR* to say that the point was to reduce the consultant-subcontractor's line items proportionately by an amount of $7,350 in order to create this outreach plan that was being advanced by the PWA Caucus. *AR* said

the other point that she needed to make was that there should have been some notification by the Contractor about unspent money or an "Unfunds Alert" in the Council's vernacular. *Jeff Byers* seconded this amendment. The meeting proceeded to a Roll Call vote *(see Attachment A, Column 2)*. The motion carried 21-4, with two abstentions. With no additional discussion, a Roll Call vote was then held on the Council Support budget after the amendment is incorporated *(see Attachment A, Column 3)*. It also passed by the same tally of 21-4, with two abstentions.

XII. Contractual Budget, Current Fiscal Year

Russ Zellers presented the budget for the current fiscal year. Basically, this is a continuation budget with the exception of the reductions already approved by the Council to bring planned expenditures down to available dollars. Delays in Title I and Title II award dollars and some reduction in Title II created a lag in the budget. He reviewed the categories and the sub-categories of the Planning Council and CARE Title 1, totaling nearly $27 million. These are the funds that are available from the Title I award for contracts; it does not include the administrative money. He detailed the other funding from CARE-Housing and the CBC that bring the total to more than $33 million (the amount that corresponds to the purview of this Council), then other sources that bring the grand total to more than $42 million for contractual purposes. The OMH grant for Technical Assistance programs is new money. He said this was presented in this format as a planning tool.

There were questions pertaining to the untimely manner in which the budget was presented, but this second Reauthorization to the Ryan White CARE Act brought delays similar to the first reauthorization five years prior. Unfunds is another topic that came up in discussion, but was related to last year's funding. Again, a Roll Call vote was taken to approve the Current Fiscal Year Contractual Budget (see *Attachment A, Column 4)*. It passed by a vote of 24 to 0, with one abstention.

XIII. Reports: Primary Care

Joseph Cecere stated that $4 million from CARE funding is spent on Primary Care, a sub-category of the health care category. The client's first encounter with the service system is generally with a primary care practitioner in tandem with a multi-disciplinary team of services. He could not provide demographic data due to problems with Reggie. He explained why some psychotherapy is considered part of the primary care package at some facilities, and a high percentage of primary care is actually case management. He provided five recommendations to improve primary care: 1) HRSA requirement to provide services to those not in care will be extremely challenging for most primary care programs since they are already at capacity and will therefore require additional funding. 2) Implement a system-wide plan for reviewing records and quality assurance at all CARE contracted programs. 3) Encourage and support improvements to multi-disciplinary team services. 4) If funding remains flat and costs for providing services continue to rise then reductions in UOS should be allowable. 5) Encourage the philosophy that human resources within the system should be respected and valued.

Charlotte Bobeck, with the Provider's Network, presented a summary of Primary Care Provider input. She reviewed some of the emerging trends that providers are seeing and said that these have created gaps in services. She said that all services work together and if there is a deficiency in one area of service it affects primary care. HIV has become a medical specialty in infectious disease. Viral resistance and "burn out" on drugs have become quite a problem. There are severe nursing shortages and an increase in demand for Complimentary Therapies. Continuity of care has been affected by funding being slashed and this too diminishes the effectiveness of primary care providers working in tandem to create a cohesive care unit. The work force is decreasing because of funding shortfalls. This definitely affects Primary Care. The amount of work that needs to be done in a range of administrative functions as well as actual patient care does not fit the dollar amount that is received. There were complaints about the amount of reporting required by the AIDS Office, beyond the funded services. Overall, the providers would like to see an effort to build upon of the system that already exists. She recommended a streamlined contract process, mental health training for providers, and a hard look at

housing issues. *JC* asked about the $1 million secured in this year's federal budget for HIV care at San Francisco General Hospital. *MLD* said a planning group is working on it. There are significant restrictions in how the funding can be utilized, for example it cannot be used for primary medical care. There is an extra application process, so this money will not become available until later this year.

At this point a motion was made to extend the time of the meeting to deliver the remaining schedule of reports. It was passed.

XIV. Reports: Complementary Therapies

Marshia Herring stated that the four programs in complementary care are: 1) The American College of Traditional Chinese Medicine, 2) The Marin AIDS Interfaith Network, 3) The Immune Enhancement Project, and 4) Quan Yin. The funding for this program was $732, 202. Approximately 2,399 individuals received services: 33 were transgender, 809 were females 1,535 male, 80 % were adults and 20% were seniors. Two recommendations that were made at the last prioritization remain as they were as there was not available funding. There is a great demand for these four programs as people are living longer and there are significant waiting lists to access services. Her recommendations: 1) Set time limits for these services or think of ways to spend less time with these clients to push the wait lists along but also maintain current funding so as not to disrupt service at it exists. 2) The impact of these services should be evaluated. 3) Continued funding is recommended.

Alyse Graham, with IEP, said the most urgent issue affecting complementary therapy is lack of funding. She stated that it is an effective alternative treatment option that benefits immune systems diminished by HIV disease and is an important component of substance abuse treatment. However, the average wait is 6-12 months to access these services. Some people have died before they ever received service. Most people are not aware of what these therapies are or can do for them because the funding for education does not exist. Studies have shown that 90% of complementary care clients have not been hospitalized in the past six months. She stated that they are in a double bind because if they take funding away from existing patients then their health will suffer. However, there is a need to reach the newly infected too. Complementary therapy is a cost effective treatment modality. Only 1.9% of CARE funding goes to this category of complementary care. Yet, with that funding, they were able to treat 65,000 since 1993. Her main recommendation was that the Council recognize and prioritize complementary health care as essential primary health care. 67% of their clients indicated that they receive this therapy in conjunction with their antiretroviral therapies. An increased level of funding would decrease wait lists and reduce hospitalizations. She also asked for a streamlined contracting process in order to allow resources to be used for the benefit of clients. A question pertained to the loss of funding to this sub-category during the past two years and how that has affected services to traditionally under-served populations.

XV. Home Health Care Services

Hilda Jones began by stating that the two main services included in Home Health Care are Facility-based Home Care and the Home-based Home Care. Both have over-achieved in their Units of Service goals. She distributed a narrative about the specific services provided. One challenge has been providing services at residential hotels to clients with very low income.

Dianne Jones, who works with Help at Home, delivered a presentation that highlighted the limits of MediCal and Medicare. She said that MediCal and Medicare will only fund home care services for home-bound people and they will only fund nursing care services for what they narrowly define as skilled nursing, which does not include medication management. CARE dollars and the General Fund contributions have expanded access to home care services that include attendant care, nursing case management, skilled nursing care, physical and occupational therapists and social workers for people who are uninsured/underinsured but not homebound. However, the number of people served is limited because clients need to have a payer source (usually MediCal) to pay for the medications and

equipment. Home Care agencies provide nursing care, IV site care, blood-draws, and teach clients how to become independent with their infusions. However, Valgancyclovir, a new drug in pill form that is awaiting approval to go on formulary lists, will transition clients off IV treatment. Funding issues are huge with home care service, and it is a complex system to navigate. *Larry Cruz* testified that he had successfully utilized infusion therapy for five years and said he would not be alive without it. He asked how a patient would get this treatment, if not covered by some form of insurance. The response was that these people lose their ability to stay at home because therapy can only be provided at SFGH outpatient infusion or at Laguna Honda. *Sam Kaplan* commented that MediCal will pay for some services in this area. *Dianne Jones* continued that Nurse Case Management in the Home is medication management and linkage to primary care.

David Powell, from Westside AIDS Case Management and Home Care, presented the Attendant Care section of the presentation. He said that Home Care is much cheaper than institutionalization and it increases the quality of life for those that receive services. In addition to funding struggles, another barrier that Home Health agencies face concerns the many clients that providers assess as needing attendant care to assist with personal needs in the home are resistant to receiving the service because of concerns around loss of independence, privacy, and disclosure to neighbors and friends. He also suggested that flat funding has eliminated their ability to provide additional services when needs increase or new consumers need services. He closed by stating that if Home Health Care Services were not provided, then higher levels of care would become necessary.

Susan Shea asked who certifies "home-bound status." The response focused on the lengthy medical assessment that the agencies must fill out and send to MediCal. The certification is done by a computer, using formulas and rules. The information has to be constantly verified and updated. *SS* also asked what changes would result from the oral form of drug therapy replacing infusion. The amount of IV therapy should decrease, but the agencies are currently seeing a rise in the use of short-term IV antibiotics and hydration therapy. *Dianne* anticipated greater numbers of clients being served for shorter periods of time. There is no breakdown of clients by income or housing status, but many clients are receiving their services in SRO rooms. *Russ Zellers* said San Francisco was lucky to have three MediCal waiver programs that provide services to PLWH. This means that Home Health Care can be provided without CARE funding.

XVI. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

May 21, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P	B	B	Y						
2. Hazel Betsey	*HB*										
3. Toni Butler	*TB*	P	B	B	Y						
4. Jeff Byers	*JB*	P	Y	Y	Y						
5. Bart Casimir	*BC*										
6. Cecilia Chung	*CC*										
7. Raymond Combs	*RC*	P	Y	Y	Y						
8. John Conley	*JC*	P	Y	Y	Y						
9. Mark Dunlop	*MD*	P	Y	Y	Y						
10. Gregory Edwards	*GE*	A	N	N	Y						
11. Donald Frazier	*DF*	P	Y	Y	Y						
12. Catherine Geanuracos	*CG*	P	Y	Y	Y						
13. Fernando Gomez-Benitez	*FGB*	P	Y	Y	Y						
14. Gene Gowdey	*GG*	P	Y	Y	Y						
15. Gary Harrell	*GH*	P	Y	Y	Y						
16. Brad Hume	*BH*	P	Y	Y	Y						
17. Sam Kaplan	*SK*	P	N	N	Y						
18. Gene London	*GL*	P	Y	Y	Y						
19. Carmen Madríz	*CM*	P	Y	Y	Y						
20. Michael Meehan	*MM*	P	Y	Y	Y						
21. Allen Meyer	*AM*										
22. Jim Mitulski	*JM*	P	Y	Y							
23. Gregory Neumark	*GN*	P	Y	Y	B						
24. Stephan Oxendine	*SO*	P	N	N	Y						
25. Wayne Peace	*WP*										
26. Ken Pearce	*KP*	P	Y	Y	Y						
27. Alissa Riker	*AR*	P	Y	Y	Y						
28. Susan Shea	*SS*	P	Y	Y	Y						
29. Janis Takamoto	*JT*	P	Y	Y	Y						
30. Bob Teague	*BT*	P	Y	Y							
31. Jose Villarce	*JV*										
32. Robert Whitford	*RW*	P	Y	Y	Y						
33. Mary Jane Wood	*MJW*	P	N	N	Y						
34. Karen Wuopio	*KW*										

21-4-2 21-4-2 24-0-1

HIV Health Services Planning Council

City Hall, Room 34 (Basement), 1 Dr. Carlton B. Goodlett Place

June 11, 2001 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes, 5/7 — VOTE**	**4:36 PM**
V.	**General Announcements**	**4:39 PM**
VI.	**Public Comment**	**4:43 PM**
VII.	**Reports**	
	• *Steering Committee*	**4:50 PM**
	- Co-Chair Elections — **VOTE**	
	- Planning Council's Definition of "Not in Care" — **VOTE**	
	• *Training: Conflict of Interest*	**5:10 PM**
	• *Marin County Report*	**5:40 PM**
	- Karen Wuopio	
VIII.	**Break**	**5:50 PM**
	• *Presentation on Substance Use Services*	**6:00 PM**
	• *Presentation on Mental Health Services*	**6:30 PM**
	• *Presentation on Food*	**7:00 PM**
	• *Discussion/Meeting Feedback*	**7:10 PM**
IX.	**New Business**	**7:25 PM**
X.	**Adjourn**	**7:30 PM**

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Thurs	6/21	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	6/25	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	6/27 or 7/4	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	6/27	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	7/9	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Thurs	7/19	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	7/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

MEMO

DATE: *June 1, 2001*
TO: *HIV Health Services Planning Council*
FROM: *"Not in Care" Ad Hoc Work Group*
RE: *Proposed Definition*

Proposal:

For the purposes of needs assessment, priority setting, program design, comprehensive planning, and other Council activities, "not in care" or "not receiving HIV-related services" is defined as:

> **People living with HIV who know their HIV status and have not seen a clinician for HIV-related medical care in more than six months.**

This definition is inclusive of those who:

- have never accessed any kind of medical care or HIV-related service since testing HIV positive,
- have accessed some social services but not medical care,
- have accessed some services including medical care in the past but are not currently getting any care or services, and
- are getting some social services but haven't been to a clinician in more than six months.

Consistent with the federal legislation and guidance from HRSA, this applies only to people who are HIV positive, have been tested, and know that they are positive.

Background:

A definition is required to implement the reauthorized legislation. In the reauthorized Ryan White CARE Act, Congress added several requirements for data collection and program development, focusing on people living with HIV who are aware of their HIV status but are not accessing health care. Below is some of the excerpted legislative language from the CARE Act, with the most relevant parts in bold. The Planning Council is now responsible for determining the population size, demographics, and needs of those who are not in care, and then for developing a plan to address their needs.

(4) DUTIES.--The planning council established or designated under paragraph (1) shall-
"(A) determine the size and demographics of the population of individuals with HIV disease;
(B) **determine the needs of** such population, with particular attention to—
i)**individuals with HIV disease who know their HIV status and are not receiving HIV-related services**; and
ii)disparities in access and services among affected subpopulations and historically underserved communities;

Rationale:

The Council needs to develop its own definition. HRSA has not yet provided specific guidance on the issue, other than a requirement to do a supplementary needs assessment for people who are not in care. HRSA has issued a summary of a meeting it held last fall on the issue. One of the first recommendations from that summary is to develop a consistent definition of "not in care." The meeting summary list some of the definitions used in various places and contexts, but does not offer one recommended definition.

To conduct its business, the Council needs a clear and agreed-upon definition. The problem with a vague definition is that different people mean different things when they talk about folks who are not in care. In order to understand the demographics and needs of a population, it is necessary to know what the parameters of that population are, or in other words, who is in that group and who is not in that group.

The work group decided that the definition should include people who:

- Have never accessed any kind of medical care or HIV-related service since testing HIV positive
- Have accessed some social services but not medical care, and
- Have accessed some services including medical care but are not currently getting any care or services, and haven't been to a clinician in more than six months.

The work group felt that the six month time frame was an appropriate middle ground. They considered longer time frames, such as a year, and shorter ones, such as three months. Six months also represents the maximum amount of time one should go between CD4 counts, according to the Public Health Service guidelines for HIV care. This definition *excludes* those who are getting services including medical care but are not consistently seeing a clinician for medical care as long as they have been to a clinic within the last six months. It would also exclude those who may be going to ER for medical care but do not have a regular clinician.

Process

At the May 7th Council meeting, the Council heard several presentations on the topic of people with HIV who are not in care. At the end of the meeting, the co-chairs requested that a work group form to develop a definition of "not in care" and bring it back to the full Council for a vote. On May 22nd the work group convened and developed the definition above. They discussed potential definitions and their implications. There was unanimous agreement on this definition.

Present at the meeting were Council members Mark Dunlop, Rob Whitford, Bob Teague, and MJay Saunders, and AIDS Office staffer Laura Thomas.

HIV Health Services Planning Council
Conflict of Interest Disclosure Form

"In order to avoid the appearance of conflict of interest in the course of Council meetings or activities, Council members shall sign a written statement agreeing to voluntarily disclose any interests in a transaction or decision where the member; member's family, including domestic partners; employer; or business affiliation, including board membership, will receive a benefit or gain. Council members should provide open disclosure and description of potential conflicts, and abstain from voting in the event of an actual conflict as determined by the Council." – Council By-laws

Please list all agencies or organizations with which you have been affiliated in the last three years which have received Ryan White CARE Act Title I funds in the San Francisco EMA or could apply for such funds in the forseeable future. Include employment, consulting, board memberships, employment of family members and partners, or any other relationship which could appear to cause a conflict of interest.

Agency	Nature of Affiliation

Signature Date

03/16/00

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Membership Committee

April Report

Meeting Date: April 19, 2001

Meeting Place: 25 Van Ness Ave., Room 330-A

Meeting Time: 5:30 to 7:30 PM

Members Present: Carmen Madriz, Greg Neumark, Ken Pearce (Chair), Janis Takamoto, and Bob Teague

Others Present: Steven Feeback, minutes; Larry Cruz, nominee; and Anthony Huynh, nominee.

Next Meeting: Thursday, May 17, 2001, 25 Van Ness, Room 330A, 5:30-7:30 PM
Meetings will generally be held on the 3rd Thursday of each month.

Introductions and Review of Agenda

Discussion with Nominees

Ken Pearce asked Anthony Huynh to go first and present some information about his background and his areas of interest. He began by saying he heard about the Council through a fellow Case Manager who knew Janis Takamoto. He then explained some work history, highlighting his HIV prevention work in Los Angeles. He was also a member of the CARE Council in Orange County California for a short time. He offered some observations regarding the Council after attending the past meeting. He said he was disappointed at not seeing higher numbers of people of color participating. He expressed his doubts about the Council's decision to revise its bylaws by increasing the numbers of HIV+ members. Even though the clients he works with in his current job as a Treatment Case Manager at the Asian Pacific Islander Wellness Center are people living with HIV, cultural and linguistic factors make them identify less with their HIV+ status and more with their ethnic heritage (primarily Vietnamese). Thus, he felt that the Council's current make-up and the revised bylaws act as a barrier to involvement by the client population he works with. He, too, would prefer to see more unaffiliated consumers as members because he understands why that group would probably be less biased and more capable of representing client needs. The question is how to achieve that. He wants to continue with recruitment efforts among the client population he serves. In the meantime, he said he would continue to advocate for those clients and, despite his affiliation with a CARE-funded agency, would make a full effort to be unbiased. He was asked how he got started in AIDS service work. He reflected on his college experience and his first experience with a community group, the Gay Vietnamese Alliance. Through that organization, he gained access to basic information about sex, STDs and HIV infection. He found himself being more interested, so it was a logical step to receive training as a peer educator. His basic desire was to deal with his own fears and share information with people who had similar fears. He has now gained a great deal of experience in HIV prevention education as well as direct services to HIV+ clients. He was asked about the cultural barriers he sees in this client population. He said the biggest barrier is access, but he is aware that there are groups of people that know services are available yet simply don't take the steps that are indicated in order to gain access. Some of his clients won't access services if it means coming to the offices because the API Wellness Center is in a building identified with HIV/AIDS services.

KP asked Larry Cruz to go next. He began by sharing some medical history—his experience in a Clinical Trail for an experimental drug that he is still taking very successfully. His health has rebounded dramatically as a result. His background, before poor health forced him into retirement, was in San Francisco city services and community projects working as an administrator. He is a native San Franciscan who has been very active for some 30 years. He helped found the Larkin Street Youth Center while working in the

Tenderloin, then moved to a position within city government. Within the Dept. of Public Health, he was an Assistant Director of Community Mental Health and Substance Abuse, then the Director of Health Center #2. His first experience with specific services for HIV disease was in 1985, as a counselor for HIV antibody testing clients. At that time, he was also on the Board of Directors for the San Francisco AIDS Foundation. He has experience with non-profit organizations as well as City government and working with the Mayor on homeless issues. His activist work involves both the Latino and the gay/lesbian communities. He is currently serving as a Board member for the Bernal Heights Neighborhood Center because he has lived in the Bernal Heights area for the past 13 years. In the past, he has been a recipient of benefits counseling services and mental health support groups (he found out he was HIV+ in 1985). Because of his city pension and related benefits, he has private health care insurance. During years of involvement, he has been put into many "categories" on a number of occasions and understands why the Council must fill certain membership categories. He is currently in the category of non-affiliated, but is not a consumer of CARE-funded services. Now that his health status is stable and some of the most debilitating symptoms have subsided, he finds himself in the position of not wasting away and wanting to contribute again. He thinks that San Francisco is a special place and wants to help ensure that the model of HIV/AIDS work developed in this city can continue.

New Member Recommendations

Considerable debate took place about the qualifications of both candidates interviewed in this meeting and the attempts to increase the members who represent the category of unaffiliated consumers. One part of the debate was focused on the criteria for evaluating who is a consumer of services. Another was the need to conduct outreach, advertising and recruitment efforts targeted at consumers of service. Both nominees were recommended by the Membership Committee. These two will be forwarded to the full Council at the next meeting.

New Member Recruitment

There was a consensus expressed that recruitment efforts will continue by sending out Nomination forms. But, during the period of Prioritization, the Membership Committee will take a pause in processing nominations in order to clarify the steps it wants to take in meeting the recruitment goals embodied in the recently revised bylaws and any instructions that come from HRSA as a result of the reauthorized Ryan White CARE Act. Laura Thomas will be asked about the definition of a consumer of services. Another inquiry will be made with the Mayor's office about the status of the current nominees. *Greg Neumark* made a motion to request money in the Planning Council Support budget for outreach, advertising and recruitment. This motion passed unanimously 4-0.

Nomination Form

Janis Takamoto agreed to spearhead the effort to finalize a new version of this form.

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May Report
Housing Committee

To: Members, HIV Health Services Planning Council
Meeting Date: May 2, 2001
Meeting Place: 25 Van Ness Ave., Room 330-A

Members Present: Margot Antonetty, Ray Combs, John Conley, Catherine Geanuracos, Fernando Gomez-Benitez, Brad Hume (Chair), and Ali Riker

Others Present: Carol Carbone, TARC; Carol Carbone, TARC; Steven Feeback, minutes; Wolfgang Stuwe, DPH (HUH); Daisy Leyva, DPH (HUH); Ramon Matos, SFAF; John Rosenzweig, Consumer Rights Advocate; and Laura Thomas, AIDS Office.

Next Meeting: Wednesday, June 6, 2001, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

General Announcements

Margot Antonetty announced that the Housing Services had merged with Urban Health into a unified department of Housing and Urban Health. She introduced Wolfgang Stuwe, who will be working as a Program Manager for some of the housing contracts funded by the Council. Daisy Leyva said a contract would be going to the Board of Supervisor's Finance Comm.—one of the master leasing hotels.

Co-Chair of Committee

Brad Hume said that Catherine Geanuracos, who had been nominated as Housing Committee Co-Chair, was considering the nomination for Council Co-Chair. For the time being, Brad said he would be trying to chair the committee by himself, knowing that he had considerable back-up and support.

Re-envisioning AIDS Emergency Housing

Daisy Leyva began with an update about the status of the three buildings under renovation: the Star Hotel (18th & Mission), the Camelot Hotel (120 Turk St.) and the residential facility, called the Broderick. There is a huge amount of work to getting these buildings ready for habitation. In addition, plans are proceeding for the 20 units of emergency housing that will be leased as a block and made available for very short-term use. Meetings have taken place to discuss the access points and procedures for these rooms. DPH wants to start the 20-unit emergency housing in September. The current contract for emergency vouchers will function until the end of September, providing a one-month overlap. They are looking for an appropriate building. Margot Antonetty said the Camelot and Star together have 105 units, with 35 earmarked for people who are HIV+ (more residents may be HIV+). Services at the Broderick Residential Care facility will be provided by Page Street Guesthouse, along with other collaborative providers. Services at the two buildings under renovation will be delivered by a collaboration of providers—Baker Places, TARC and LSS. There is also professional property management. DPH is in the process of working out contracts and budgets, in preparation for going to the Health Commission. Ali Riker clarified that both the Star and Camelot are buildings that will be fully under master lease agreements between DPH and their respective owners. Both buildings will offer longer-term, transitional housing (SRO with shared bath). Residents will pay approximately 50% (as with other DA buildings—Direct Access to Housing) of their income toward rent. Money Management is a service that will be provided to those residents who want it. This service may include accumulation of a security deposit. Because this is stable, clean, maintained housing, not many clients will want to move out. Therefore, DPH is anticipating longer-term occupancy. *Margot* mentioned

the supportive services (including food) again, as well as the desire to create a sociable environment for the residents. She sees this arrangement as workable: 50% of income invested in something very worthwhile for the residents. Temporary shorter-term emergency shelter is also available in this new configuration, including six beds in the RCF offering medical care and respite. *Margot* said some people will want to move out of the transitional buildings. The Money Management service will hopefully be attractive to the clients and improve their self-sufficiency. The reality is that a program can be designed in order to provide a truly transitional (24-month) housing experience, but in this City the resident cannot be forced to move out, even if the person does not fulfill some mandatory responsibilities. Mandates are not legal, so all that can be done is to make good money management habits part of an attractive set-up for residents. A number of agencies will function as referral sources (slots allocated to agencies that line up appropriate clients) for the eventual applicants. Case Managers will be responsible for filling out part of the application. In theory, the agency is in the best position to place clients, but there is an interview process with the property management as well. DPH is looking into the feasibility of various SRO hotels for siting the 20 emergency rooms. Protocols are being devised for how to determine the length of stay in these rooms that will replace the voucher system of the past. The maximum stay is probably going to be the traditional 28 days, and 60 days in the respite care facility for medical necessity.

Laura Thomas said the two hotels are being converted to utilization as independent living facilities with supportive services. Health status can change with HIV disease, and many providers and patients alike are accustomed to seeing every form of care as transitional. But, just as drug regimens can become stable, so can housing. Home health care services can sometimes be used to assist with individual clients who need a greater level of medical care. It is a difficult decision to make as to the normative level of supportive services to provide in the context of general independent living. Residents have to be able to handle that level. It is not a 24-hour care facility. However, many of the residents will have health conditions that complicate their lives, including conditions that can deteriorate. Staff should be trained to handle many different situations. DPH Housing and Urban Health is trying to create models that understand the impact of a person's housing situation on their overall health and how to provide appropriate health care services in the context of a living environment. *Ali Riker* continued to ask about some clients who might not do so well in a housing interview by the property management company of John Stewart. *MA* replied that clients make it through the application process, who have a Case Manager who is invested in the success of their application. Four missed appointments are allowed. Criminal background checks are done for liability reasons, and people with records are allowed in. *Daisy* added that there is a great deal of effort put into creating a good environment in the building, while balancing that with the desire not to reject people unless there is a clear justification. The tolerance level is very high in the DA buildings, which have different criteria than Derek Silva, for example, where there is a cultural divide between long-time residents who have just managed to stay alive with HIV disease and the newer residents who are dually diagnosed and accepting of harm reduction as a way of life. This is not the case in the DA buildings. A challenging population lives in these buildings. Behavior gets addressed, but people are not excluded. There are about sixteen standard and integrated agencies that can make referrals of clients. Details are still being worked out about the access points.

Presentation to the Council

BH reported the progress of a small work group (Brad, Catherine & Margot) working on preparing the Housing presentation that will be given as part of the Prioritization process of the Planning Council. The presentation is scheduled for the July 9 Council meeting. *Laura Thomas* went over some of the guidelines for presentations, which are being planned for all service categories.

Needs Assessment Activities

AR asked what was being planned. *Laura Thomas* explained that a mini assessment would be done, focusing on people not in care. She anticipated that it would be difficult to get useful information. She also said it was not too soon to start planning for the next major Needs Assessment study.

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2 May Report - PWA Caucus Meeting

Meeting Date:	May 2, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:30 PM
Members Present:	Cecilia Chung (Co-Chair), Ray Combs, Gary Harrell (Co-Chair), Brad Hume, Jim Mitulski, Wayne Peace, and Robert Whitford.
Others Present:	Edward Patterson, (Council nominee and consumer of services). Steven Feeback, minutes. Marsha Herring, Joseph Cecere and Michelle Long-Dixon, (AIDS Office). and Jonathon Rosenzweig (HIV Consumer Rights Advocacy project).
Next Meeting:	Wednesday, May 16, 2001, 25 Van Ness, Room 330-B, 5:30-7:30 PM

Welcome and Introductions

Cecilia Chung called the meeting to order. Members introduced themselves and approved the meeting agenda.

Announcements

General information on the FY01 budget and the Council Support budget will be reviewed at the next Planning Council meeting on May 21st. *Catherine Geanuracos* has allowed her name to be put forward as a nominee to fill the Co-chair's term until September 2001.

Report from the Consumer Rights Advocacy Project

John Rosenzweig gave a report on the new cases that the Consumer Rights Advocacy Project had taken on. *Please see attached information.* There were five recent cases. The first was a client who filed a grievance with the assistance of the Advocacy project, and is simultaneously utilizing the grievance procedures of the SF Human Rights Commission. The second case involved a client who had a HOPWA/Section8 voucher and found a building willing to accept him, but was still being denied by the Housing Authority due to a dispute over the amount of the security deposit. The third and fourth cases surrounded domestic partners and claims that their case manager was discriminating against them. Lastly, a client with dementia complained that he was experiencing difficulty securing an appointment at UOP. This brought forth a brief discussion pertaining to PLWH and the need for better dental care. It was agreed that this topic would be addressed at a future meeting as part of the Prioritization process.

Meeting Schedule

Cecelia introduced the idea of having an extra meeting in order to put together a consumer questionnaire that is due by July 1st. Council members who are also providers have been invited to attend Caucus meetings in order to provide some input on methodology. The Caucus agreed that as many segments of the HIV/AIDS population as possible should be targeted in order to reflect a cross-section of services in the city. The number of questions and the nature of the questions would be addressed at the next Caucus meeting. A motion was made to have an additional meeting this month (May) to finish work on the questionnaire. It was a unanimous vote to accept that plan; May16th at 5:30pm was agreed upon as the date for the extra meeting.

Membership Issues

CC said that the recently adopted by-law amendment states that 67% of the Council membership must be comprised of PLWH and 40% of unaffiliated consumers. There was discussion pertaining to the active recruitment of the aforementioned populations. *Edward Patterson* suggested that each Council member take some responsibility in the area of recruitment. *CC* stated that the Council was in need of more participation from HIV+ people of color, HIV+ women, and HIV+ youth.

New Business

Wayne Peace presented his concerns regarding dental care. He said that his dental insurance contains a cap, and he wanted to explore some changes in how dental care is handled by providers funded under the CARE Act. He was encouraged to get appropriate treatment for his particular situation, using his insurance (up to the cap) and other methods after that. During Prioritization, dental services in general will be a topic of discussion in the full Planning Council. There is a great deal of interest in that service category.

HIV CONSUMER RIGHTS ADVOCACY PROJECT
1540 Market Street, Suite 301
San Francisco, CA 94102
Tel: 415.863.8131
Fax: 415.863.0831

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PWA CAUCUS – APRIL 2001 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Pending
2-	Dental	UOP	Quality of Care	Pending
3-	Housing	Catholic Charities	Access to services	Pending
4-	Housing	Catholic Charities	Unauthorized Disclosure	Resolved
5-	Other	AHP	Access to Services	Pending
6-	Other*	SFAF	Access to Services	Pending

1- Client claims that he not only received unsatisfactory services from UOP dental clinic, but also that after one year his dental needs have not been fully addressed. The client filed a grievance in the form of a memo addressed to the Advocacy Project, which was forwarded to UOP. UOP referred the memo to their attorney, and responded to the client's memo with a dismissal from the UOP program and a referral to Community Dental. UOP's attorney asserts that the memo was not a grievance, and insists that UOP has no further obligations to the client. The client, an attorney, wishes to prepare his own response to the attorney, and is in the process of doing so.

2- Client claims that he has been mistreated by staff and professionals at UOP over the past few years. and that inappropriate notations have been made in his dental charts regarding his behavior. Client believes these notations have damaged his reputation at UOP, and that he would be subjected to further mistreatment if he were to continue as a patient at UOP. Client filed a grievance against UOP regarding several alleged incidents of mistreatment and improper notations, and UOP has responded. Client is dissatisfied with UOP's response, and the Advocacy Project has arranged a meeting among the client, UOP administration, and the Advocacy Project. The Advocacy Project has also forwarded a copy of the client's grievance and UOP's response to the AIDS Office at the client's request.

3- Client claims that Catholic Charities denied him a housing subsidy because they could not reach him by telephone. Client has voice mail, but no telephone service. Catholic Charities staff left client a series of messages informing him he had qualified for a housing subsidy to pay past-due rent, and

asking client to call to set up an intake appointment. Client returned the telephone calls, but could no reach the person who left the messages, and left a series of messages for Catholic Charities staff informing them when he would be available to come in. When client finally reached the staff per by telephone, she informed him that the subsidy had been awarded to someone else. The client filed a written grievance on his own, then contacted the Advocacy Project for assistance. The Advocacy Project contacted Catholic Charities and arranged for the client to reapply for the subsidy under revised procedures. Client has not decided whether he wants to further pursue his grievance.

4- Client claims that staff at Catholic Charities made an unauthorized disclosure of his psychiatric history to the president of the tenants association of a building into which he was planning to move. According to the client, this disclosure damaged the client's reputation and denied him potential housing, since he feels that he could not live in a building where residents know his psychiatric history. Client also claims that Catholic Charities has done an inadequate job of finding him housing where he can use his housing subsidy, and that SRO hotels to which he was referred were uninhabitable and too expensive. Catholic Charities maintains that it does not find people housing, and does not vouch for the quality of the hotels to which it refers clients. The Advocacy Project assisted client in drafting a grievance addressing his concerns, and attempted to facilitate communications with Catholic Charities regarding his immediate housing needs. Client also contacted the San Francisco Human Rights Commission, which has sent a letter informing Catholic Charities of the unauthorized disclosure and requesting that the staffperson responsible for he disclosure be disciplined.

5- Client claims that AHP created barriers to its services that amounted to a denial of reasonable accommodation. The client had requested a telephone intake due to severe fatigue and limited vision and AHP insisted that he come to its office for three separate appointments before he was referred a therapist, and then required him to wait four to five months for an appointment. Client feels that the therapist he was assigned to provided inappropriate counseling. According to the client, the therapist also refused to accommodate his request for a two week break in his therapy sessions, claiming it was AHP's policy not to allow such a break. The Advocacy Project is assisting the client in preparing a grievance addressing the issues raised by the client's experience with AHP.

6*- Client claims that SFAF created barriers to its services that amounted to a denial of reasonable accommodation. According to the client, who has severe fatigue and limited vision, the SFAF required him on two separate occasions to come to its offices for services that could have been provided over the telephone or at his home. When he arrived for these appointments, he was required to wait 45 minutes for the first appointment and 1½ hours for the second appointment. The client also believes he was misinformed about the services to be provided at the second appointment, which he believed was for the purpose of meeting with an ALRP attorney to prepare a will and powers of attorney. The appointment was in fact with an ALRP staff attorney to do an intake for referral to a volunteer attorney within two to three months. The Advocacy Project is assisting the client in preparing a grievance concerning the SFAF's procedures. The Advocacy Project also contacted the ALRP to arrange for an expedited referral due to the client's medical condition.

* Duplicated Client

NEW CASES

	Service	Agency	Issue	Outcome
1-	Housing	Black Coalition on AIDS	Discrimination	Pending
2-	Housing	Redevelopment Agency	Restrictive Policies	Resolved
3-	Case Management	Tenderloin AIDS Resource Center	Quality of Service	Pending
4-	Case Management	Tenderloin AIDS Resource Center	Quality of Service	Pending
5-	Dental	UOP	Quality of Service	Resolved

1- Client believes that the Black Coalition on AIDS/Rafiki Housing Program/Brandy Moore House has denied him housing based on a staffperson's knowledge of his prior use of medicinal marijuana in another program. Client filed a grievance with the assistance of the Advocacy Project, and is simultaneously utilizing the grievance procedures of the Human Rights Commission.

2- Client had located an apartment that would accept his HOPWA/Section 8 subsidy and his cat. However, the Housing Authority, which administers the HOPWA/Section 8 program for the Redevelopment Agency, refused to approve the lease agreement. The lease agreement required a tenant security deposit in excess of the amount allowed by the program, but the tenant was willing to pay the full amount and had enough money to do so. Both the landlord and the Housing Authority refused to compromise. The Advocacy Project contacted the Redevelopment Agency, which agreed to remove the restriction on the amount of a tenant's security deposit in cases where the landlord insists on a higher amount and the tenant has the ability to pay that amount. The client and his cat are in the process of moving into their new apartment.

3&4 Clients, who are domestic partners, have a number of complaints about their case manager at TARC, primarily relating to his failure to get them into permanent housing, but also involving poor communication and failure to give clients food vouchers and housing vouchers. Clients believe they may have been discriminated against. The Advocacy Project arranged a meeting among the clients, the case manager's supervisor and the Advocacy Project where the clients presented their complaints, and the TARC supervisor responded informally to some of their complaints and arranged to have the clients transferred to another case manager. The TARC supervisor is in the process of preparing a formal response to their grievance.

5- Client, who has memory problems, complained that he had had problems trying to make an appointment at UOP, and that his phone calls to the UOP CARE program had not been returned. The Advocacy Project called the UOP CARE Program Coordinator, who explained that he was awaiting medical records that he had requested from the client's physician. He agreed to call the doctor's office again to follow up on the request, and to schedule the client to come in the next day to be seen for discomfort the client was experiencing.

Referral Calls:	ALRP	3
	St. Mary's Medical Center	1
	We Care Bay Area	1
	SFAF Case Management	1
	Project Inform	1
	Positive Resource Center	1
	Total	8

(Report prepared by John Rosenzweig on 5/2/01)

16 May Report - PWA Caucus Meeting

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Meeting Date:	May 16, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:30 PM
Members Present:	Cecilia Chung (Co-Chair), Greg Neumark, Robert R. Whitford, Janis Takamoto, and Catherine Geanuracos.
Others Present:	Edward Patterson, Council nominee and consumer of services. Steven Feeback and Christopher Murphy, minutes. Laura Thomas AIDS Office
Next Meeting:	Wednesday, June 6, 2001, 25 Van Ness, Room 330-B, 5:30-7:30 PM

Welcome and Introductions

Cecilia Chung called the meeting to order. Members introduced themselves and approved the agenda. Cecelia made a brief statement pertaining to the questions that the Council needs to devise by the end of the meeting. The focus of the questions will identify how people living with HIV feel about the services that they have been receiving. She suggested that the questionnaire be distributed at the grocery center and other consumer populated places.

Planning Council Support Budget

Greg Neumark said he wanted to amend the Council Support budget, specifically the consulting line items. He explained that the last three consulting sub-contracts noted in the budget were not entered into as yet, and he felt that the quoted amount for consultants' hourly rates should be changed. His reason for wanting to make this change was, in part, because many PLWH live on very limited incomes and it seems extreme to him to be paying such high rates to consultants. Greg wanted to see the difference from the reduced amount that would be paid to subcontractors dispersed as follows: 1) an additional $2,000 to outreach materials, 2) $4,500 for outreach consulting at the pay rate of $15.00 per hour for 300 hours of outreach, and 3) the $850 remainder for salaries of the Administrative Coordinator and the Administrative Assistant ($500 and $350 respectively). Greg was surprised that there was $41,000 remaining unspent from last year's budget and that the Council was not made aware of this. *Laura Thomas* commented that the Grantee (DPH) and the Contractor (PRC), not the Council, handled the actual negotiation of line items in the budget. She said that the Prioritization Organizing Committee had voted at its 5/14 meeting to approve the Planning Council Support budget. She indicated that perhaps it was too late to make further changes. Greg countered that the Ryan White CARE Act gives authority to the Planning Council to alter provisions of the Council Support budget. He added that the three items in question were sub-contracts that had not yet been finalized. Members generally concurred with Greg's proposal of reducing the subcontractor's fees but were not comfortable with the rate that Greg proposed. *Catherine Geanuracos* inquired if the Council had the authority to vote yes or no on this budget, and, if so, could the Council also make specific recommendations. Laura stated that yes, the Council had the power to vote either yes or no on the budget, and they had the power to make recommendations. However, the Council usually does not set the number of hours and the rate of pay that sub-contractors should receive. With this additional information, a vote on Greg's amendment was requested. The result was a 3-1 tally in favor of the amendment with two members not participating due to a lack of information.

Consumer Input

Cecelia reported that she had met with staff at Project Open Hand to discuss the possibility of distributing the questionnaires at the grocery center. She stated further that she has contacted other agencies that have conducted forums and groups. *Catherine* added that she had just completed a focus group for clients of Larking Street Youth Services concerning their services. The focus group included HIV-positive youth and at-risk young people. Catherine said that it was important to understand why people dropped out of services and why people did not pursue services. Gay youth, youth of color, and young women were specifically targeted for this study. She said that what they found was that the lack of confidentiality kept a lot of people out of services. This was true especially for people of color. The study also indicated that young people took up to a year and a half to seek services after they tested positive. Participants reflected that the peer advocacy group available at Larkin Street was key to their ultimate decision to seek care. Catherine said that in regards to her findings, the smaller discussion groups worked best and that perhaps a smaller number of questions would work better. Cecelia opened the group to discussion on possible questions for the consumer questionnaire.

The Questions

The group went through considerable discussion in order to arrive at the following questions:

- *What is the most helpful service?*
- *What turns you off to services?*
- *What has been the most important to you?*
- *What makes for a good service?*
- *What do you need that you are not getting?*
- *What keeps you from getting the services that you need?*
- *How satisfied are you with the services that you have gotten?*

The group determined that most of these questions would be multiple choice.

New Business: the meeting scheduled for the Fourth of July was switched to June 28th. Also, one more extra meeting may have to be scheduled in between the June 6th and the June 28th meetings.

HIV Health Services Planning Council Questionnaire

The HIV Health Services Planning Council is a group of community representatives, including people living with HIV, who set funding priorities for HIV services in San Francisco. We are distributing this anonymous survey so we can learn more about your experience using services for people living with HIV. In order for the Planning Council to make decisions that will improve HIV services in San Francisco, we need to know if you are receiving the assistance that you need. We are interested in your experience with all HIV-related services you have used or are currently using, not just your opinion of the program where you received this survey. Your input is very important and we thank you for taking a little bit of your time to answer these questions.

What are the most helpful services you have received in the last six months?

____ *Primary Medical Care*
____ *Case Management*
____ *Substance Abuse Program*
____ *Mental Health Counseling*
____ *Dental Care*
____ *Other:*
____ *Money Management*
____ *Housing*
____ *Food*
____ *Transportation*
____ *Legal Assistance*

What services have you needed during the past six months that you did not receive?

____ *Primary Medical Care*
____ *Case Management*
____ *Substance Abuse Program*
____ *Mental Health Counseling*
____ *Dental Care*
____ *Other:*
____ *Money Management*
____ *Housing*
____ *Food*
____ *Transportation*
____ *Legal Assistance*

What makes for a good service?

What keeps you from getting the services that you need?

How satisfied are you with the services you've received? 1 = extremely dissatisfied; 10 = extremely satisfied

1 2 3 4 5 6 7 8 9 10

Your Age:

Your Gender:

Your Zip Code:

Your Race/Ethnicity:

Your Sexual Orientation:

Your Income Level: $0-$500 $500-$1000 over $1000
(please circle one monthly income category)

Minutes, June 11, 2001 HIV HEALTH SERVICES PLANNING COUNCIL
Draft until approved by Council at next meeting

DRAFT

I. Call to Order
4:30 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was not present at the start of the meeting, but additional members arrived within a few minutes.

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III. Review and Approval of Agenda
The agenda was reviewed and approved.

IV. General Announcements
Jim Mitulski stated that this meeting would use a format that varied from the previous meeting. Comments from the general public would be heard during the scheduled time slot on the agenda. Then following presentations, questions would only be taken from Council members. If time permitted at the end of the meeting, additional comments or questions from members of the public would be allowed. This was being done in order to complete the agenda and not fall behind schedule. *Susan Shea* announced an upcoming meeting of the Prioritization Organizing Committee.

V. Public Comment
Charlotte Bobeck, a member of the Executive Committee of the San Francisco HIV and AIDS Provider Network (HAPN), read a letter that addressed the concerns of providers that had attended the May 21 Council Meeting. The body of the letter stated that the providers were rushed in their time slots because other agenda items ran longer than expected. She stated that the providers felt they were not heard or respected as experts in the field, and the information that they had prepared was lost in the hurry to complete the presentations. The letter asked that the providers in Primary Care, Complementary Therapy and Home Health Care categories be allowed to submit further information to the Council and be allowed to answer any additional questions. *JM* responded by apologizing for the inconvenience and the difficulties with the meeting. He explained that no disrespect had been intended. He also thanked the providers for the energy put into their presentations. *Laura Thomas* distributed copies of the HIV/AIDS Epidemiology Annual Report.

VI. Review and Approval of Minutes
5/07/01 Council Meeting Minutes – two corrections were requested. It was then moved to adopt the Minutes. By voice vote, the Council Meeting Minutes were unanimously approved. Two members abstained.

VII. Reports
VIII. Steering Committee
JM announced the need to proceed with elections for the third Co-Chair position. Catherine Geanuracos was the sole candidate. That being the case, there was no need for a paper ballot. Catherine was unanimously approved, and she was welcomed as new Co-Chair. *JM* also announced that Stephen Oxendine would not be seeking re-appointment when his term expires and would be stepping down after the July meetings. This action will mean that he will be resigning as one of the three Co-Chairs at the same time. The Council will be seeking a replacement, keeping in mind that an election for all three Co-Chair positions is scheduled for September in any case. Anyone who is prepared to step forward before the general election in September must be a man or a woman of color regardless of HIV status.

IX. Planning Council's Definition of "Not-In-Care"

Mark Dunlop explained the discussion that had taken place concerning the proposed definition among an ad hoc group composed of *Rob Whitford, MJay Sanders, Laura Thomas,* and *Bob Teague*. One of the Reauthorization mandates of the Ryan White CARE Act was for the Council to determine the needs of individuals who know their HIV status but are not receiving HIV related services. Also, a strategy needed to be developed to find a way to get these individuals into care. The definition: **People living with HIV who know their HIV status and have not seen a clinician for HIV related medical care in more than six months.** He pointed out that the definition is inclusive of those who have never received HIV services since testing positive; those who have accessed some social services but not medical care; those who have accessed some services including medical care in the past but are not currently getting any care or services; and those who are getting some social services but haven't been to a clinician in more than six months. There were questions about what kind of clinicians and the role of emergency room visits. Susan Shea spoke in favor of the proposed definition, as a beginning and a working concept. It was moved and seconded to approve this definition. The motion passed by a unanimous vote.

X. Training: Conflict of Interest

Laura Thomas introduced Norm Nickens, a former member of the Council who was then Deputy Director of the AIDS Office and is now Deputy Director for Affirmative Action and Cultural Competency for DPH. His training topic was Conflict of Interest. He stated that there was not a crystal clear definition of conflict of interest. However, he said that a general understanding of the rules that apply to the Council and some guidance pertaining to the application of those rules would be covered. He went through some of the legal issues surrounding conflict of interest (the Council is not a non-profit Board of Directors or a legislative body). California Fair Political Practices Act, which the Council refers to in its By-laws, according to *NN*, was not the complete package for the Council because it is designed to avoid economic conflict in a political setting. He stated that those types of conflicts were not likely to arise for Council members because they did not have power over contracts. *NN* covered three types of conflicts: 1) Stress Conflicts: illegal conflicts; 2) Potential conflicts: may be offensive but are not illegal; and 3) Perceived Conflicts: could create distrust among Council members or between the Council and the public.

The California Fair Political Practices Act is designed to prohibit expressed economic interest or receiving direct economic benefit. Non-profit organizations are different in that their activities are usually organized to benefit the public rather than employee's personal interests. The work of the Council usually does not involve any direct personal economic interests. Special Issues Affecting the CARE Council: the Mayor appoints members, and this means that the work of the Council does fall under definitions provided in the Fair Political Practices Act. He cautioned the Council to take care in recognizing their obligations and the legal repercussions of their decisions. This does have some legal significance because members are asked to provide personal economic statements yearly and the Council itself asks for disclosure of any type of affiliation with a CARE-funded agency. The Council does not fall under additional City requirements because it is not mandated by the City Charter. He said that Council members do have the right to participate in discussions and votes, but Council members should decline to participate or vote if there is any type of economic interest in the outcome. Even potential conflict should be disclosed during discussion, and the individual probably should not take part in any vote related to this issue. He illustrated this with examples. He said the Council allocates funding by service category, not to individual contracts or people. Some categories have a small number of service providers, and this is where the perception of a conflict of interest can occur. When any issue before the Council touches too close to an agency that a member has an association with, that fact should be disclosed and it would be proper to abstain from voting. Some economic issues are of a more general nature and have an impact on all agencies rather than any single agency. In this case it is not improper to fully participate in discussion and voting. All of this is complicated slightly by the nature of non-profit agencies, in which direct economic benefit is hard to demonstrate. Still, it is

advisable to avoid even the perception of conflict. He issued a special caution about the areas of Council Support and Council logistics. He went on to answer specific questions, which involved examples that members had questions about. One point he made was that the Council does not now have a specific process for judging each other's actions. It depends on the capacity of each individual member to openly disclose. Challenges may arise after an action by the Council. He also offered his opinion about the position of public sector employees and pointed out that their level of salary is not affected by anything the Council does. Employees of DPH may have an interest in the outcome of a discussion and it may impact their work with individual agencies, but it is generally accepted that this does not translate into any economic benefit. He encouraged every member to pass judgement on his or her own actions and provide the disclosure of potential conflict, not try to police other members. He briefly discussed how challenges are handled through a grievance process. A member who does not disclose his interests or participates in a vote involving his interests can run the risk of having that vote thrown out. He was asked if consumers of services could face potential conflict of interest. *NN* responded that there could be a scenario with funds being cut, in which an individual consumer would defend a particular service category from cuts based upon his or her own usage of that service. He advised self-disclosure and honesty. He didn't offer his opinion about voting in such an instance. Generally, consumers of service are not considered to have a conflict in such cases and can vote, according to the Fair Political Practices Commission. Recipients of service may have a bias related to that service, but the amount of service received does not translate into an economic stake in the issue. He advised members to express themselves on these issues and not allow unspoken perceptions to grow into problems. Members are experts in some area related to services and should feel free to express themselves in an open and honest manner.

XI. Marin County Presentation

Susan Shea introduced Karen Wuopio. *Karen Wuopio,* Director of the AIDS Program for Marin County's Department of Public Health, said she prepared written materials based on the data the county, including the prison at San Quentin. As of last month, Marin had 357 living AIDS cases. African-Americans are the most disproportionately affected population comprising 3% of the overall population yet represent 7% of the living AIDS cases in men and 8% in women. Women have held steady in comprising 10% of the total AIDS population. However, despite these numbers, the most affected population in Marin is gay white males between 30-49 years of age. Seventy-six percent of the HIV population has an AIDS diagnosis. She discussed the distribution of housing situations. She stated that 71% of Marin's patients have monthly incomes of $900 or less. In terms of insurance, 11% are uninsured, 55% have some type of public insurance, and 24% are insured privately. Hospitalizations have decreased and so has mortality.

The greatest challenge to the county right now is treating patients who are doubly and triply diagnosed. Emerging needs involve serving monolingual Spanish speakers, greater mental health services and the lack of affordable housing in the county. Marin County has eight Title 1 service providers. They received about $1.5 million last year in Title 1 Funding. The bulk of that funding went to Primary Care facilities (the County HIV Clinic). This category also includes alternative therapies like acupuncture and vitamin/herb vouchers. The second highest recipient of their CARE dollars was case management offered at the County HIV Clinic or through an AIDS service provider in the community. Case managers tend to provide a high degree of individualized assistance.

XII. Break

XIII. Reports: Substance Use

Celinda Cantu, Program Manager with DPH-HIV Health Services presented. She delineated her background and proceeded with handouts that defined the types of services. She stated that the average Residential Detoxification service included a 21-30 day stay for substance abusers. However, she specified that duration of time should not be looked upon as a consideration when determining if a

client has been effectively treated. Substance Abuse Residential Detox services are certified for the care provided and not the individual practitioner. Individual counselors may be certified, however, other agencies may not choose to elect that type of recognition for their facility. She said that in California, the definition of chemical detox counselor is not fully developed and therefore can be problematic when attempting to secure a staff. Citywide substance abuse services have roughly a $35-55 million budget, however the city is still not able to provide treatment on demand. Over the last ten years, substance abuse treatment delivery has had to be redefined. Recovery, prior to the HIV epidemic, promised "angel kisses" and all good things if you recovered. HIV changed the fabric of that philosophy forever. Sex and death now had to be incorporated in recovery as well as the distinction between social drugs and medication. Staffing has also changed in the past ten years in terms of an increase in services to patients.

Judith Stevenson, from Baker Places, commended the Council for its attention to housing issues and to harm reduction. She addressed the unmet needs in regard to substance abuse care and said that the most urgent is still residential treatment programs. Transitional residential treatment is key to recovery for addicted people. It is there that some clients will go into primary care treatment for the first time hence the linkage between substance abuse and primary care. Women are not being reached by programs and require women-specific programs. She said that shifting dollars from one program to another does not increase the effectiveness of a program rather, reduces systemic effectiveness. She urged the Council to help promote change within DPH to stop managing the Contractors like nations at odds with each other and to consolidate the contracting process. *Jim Beck,* from the Haight-Ashbury Free Clinic, offered his input about treatment on demand and harm reduction. He hailed advances in understanding that have come with the impact of HIV on substance abuse treatment, leading to more gay-sensitive treatment and an association with other diseases such as hepatitis. He agreed with Judith that CSAS (Community Substance Abuse Services, another division of DPH) would not be an alternative source of funding for treatment to HIV+ clients, if CARE-funding were taken away. Most clients are dually and triply diagnosed. He applauded the Council for its focus on "Severe Need Populations." He concluded by saying that staffers for substance abuse contractors are paid very low wages. This creates a revolving door of personnel and thus inhibits clients' recovery.

Peter Fogle, Manager of HIV services at Walden House, talked about the inter-connected nature of services for the population of HIV+ substance abusers. He advocated for dealing with the most urgent need first and then following through with the array of issues that a client has, helping them access all their other client services, including primary care. He said residential services are full and there are times when clients don't have anywhere else to go when they finish treatment. Every place is operating at full capacity. *Latiffa,* a substance abuse counselor, gave the example of a client in recovery who was a former prostitute fighting to get her life together utilizing public service programs. She is getting ready to be released and will live with her teenaged daughter who is mentally challenged. Latiffa stated that this woman could not have survived with HIV disease without the services she received once she decided to get her life together. She said they have only six slots in their program and a number of women waiting to get in. Questions surrounded the numbers of beds designated for women and wait lists for women. Peter stated that the lists were not long at Walden House because it was more difficult to get women into treatment and assist them stay to completion. There are wait lists for everyone. Questions also had to do with the impact if any of Proposition 36, mandating diversion to drug treatment instead of prison for some people. It may be that an influx of new clients will overload the system, and it may not. This is too new.

XIV. Reports: Mental Health Services

MJay Sanders introduced *David Macias* who is an HIV Health Services Program Manager and deals with mental health services. A number of extensive handouts were made available. He outlined the four types of service provided in this category: outpatient mental health, psychiatric consultation, crisis mental health, and residential mental health services. He said that all programs had met their projected

numbers for units of service and unduplicated clients, with the exception of UDC in the area of psychiatric consultation. He said that people who require mental health services in San Francisco are getting those services. He presented demographic information, but the use of the overhead projector presented difficulties in this meeting room (Room 34 in the basement). He presented three recommendations: Continued focus on funding for programs serving multiple diagnosed clients with HIV/AIDS, mental illness and substance abuse; Continued expansion of integrated service delivery models; and A system-wide training conference on the treatment of multiple diagnosed clients.

He presented four providers of mental health services in San Francisco. *Jim Dilley,* of AIDS Health Project, presented some aggregate data collected from all the HIV mental health providers about income level, housing status and the percentage of clients with both a mental health and a substance abuse disorder (these charts were also in the handouts). He said that an analysis had revealed that some 30% of clients served by funding from CARE were probably eligible to receive MediCal funding. That realization had led to a reduction in CARE funding, some of which was subsequently restored by the City and other federal sources. Not everyone can satisfy MediCal criteria. *Estella Garcia,* from Instituto Familiar de la Raza, advocated continued support for mental health services to the severe need population of uninsured and underinsured individuals. She advocated for mental health service as a vital part of a whole system of care, which needed continued support from the Council. She presented vignettes about client needs and the client in context of a whole community. She showed that mental health services are about saving lives and providing some quality to life. It is about the spiritual well-being of people. *Joe Neisen,* from New Leaf, said that level funding means decreased services. The cost of providing service has gone way up. Non-profits cannot retain staff because of low pay scales. *Laura Feren,* of the Family Service Agency, spoke about the work of the Mental Health Workgroup. This workgroup has improved the integration of services and translated into higher levels of reimbursement for services. The group has spearheaded efforts to provide more outpatient services. Their client loads have increased 10%.

XV. Reports: Food Services

Brad Hume introduced this category and *David Macias,* again had the role of Program Manager. He said there are three providers in this category. They provide delivered meals, nutrition counseling and food solicitation. He provided handouts that explained each part of the service. His recommendations were that meals provided should be consistent with dietary requirements for individuals taking anti-retroviral medication; that clients should continue to be able to choose food vouchers and grocery bags; that continued close communication should continue between registered dietician, primary care provider and meal prep staff; and that continued funding should be at the current level.

Jim Illig spoke next. He stated that providing food is no longer just about eliminating hunger. For people with HIV it is a necessity to prevent wasting and allow medications to work. There are very specific nutritional requirements for people with AIDS that are far beyond that of ordinary adults. The meals delivered provided calorie requirements and appropriate number of meals per day. Nutritional counseling is also part of the service that is provided. This part of the service informs clients about how to eat well and that just taking medications will not (alone) keep them well. Because of the nature of this service, food, he sees a large majority of people that are not in Care. Food service is important for many clients because they are required to get themselves certified by a doctor to receive food, placing them in contact with primary care. Each client must become re-certified every six months. This category feeds 1,200 people with CARE money and another 3,000 people with private money. In this fashion, Jim said his service pulls people from out of care into care. The group that his organization does not reach is asymptomatic. Because they are not HIV symptomatic, they cannot receive groceries but are permitted to receive nutritional counseling. He stated that the clients are primarily poor and are a culturally-diverse group. There is currently no waiting list for services. CARE funding is less than 25% of what is needed in this category. Questions from the Council centered on the energy expenses that are required for running these establishments. Because of the rolling black outs, they have

developed a cold food menu and other blackout backup plans. The number of people not being served is the focus of a study being done now and the results should be available sometime this summer. Homeless people generally receive food items that can be opened and eaten immediately without heating or utensils. He said that roughly 5% of the people that they serve are homeless in San Francisco.

XVI. Meeting Feedback

Susan Shea said that email feedback will now be solicited following each meeting. *Brad Hume* felt that the training was good. He liked written recommendations. He felt it was helpful for presenters to provide the answers to the specific questions that the Council had put forward. *Cecelia Chung* felt that separating mental health issues from substance abuse was a disservice since many speakers spoke about the many ways that these two categories overlap and the providers work together. Housing must be considered part of this continuum of service as well. She called for more Council discussion about this integration of service categories. *Jim Mitulski* wondered what recommendations the service providers would offer should their funding be cut. He stated that he hears that levels of funding need to be maintained but the reality is more one of being faced with cuts that may be inevitable. "Where do we cut if we must?" He suggested that the service providers who speak to the Council explore some alternatives and provide the Council with suggested ways to advocate for funding outside of CARE funding. There was a general consensus that the presenters were educational and informative. The process of the meeting was deemed better due to better organization and *Susan*'s facilitating of the process.

XVII. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

June 11, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P									
2. ~~Hazel Betsey~~	*HB*	—									
3. Toni Butler	*TB*										
4. Jeff Byers	*JB*	P									
5. Bart Casimir	*BC*										
6. Cecilia Chung	*CC*	P									
7. Raymond Combs	*RC*	P									
8. John Conley	*JC*										
9. Mark Dunlop	*MD*	P									
10. Gregory Edwards	*GE*										
11. Donald Frazier	*DF*	P									
12. Catherine Geanuracos	*CG*	P									
13. Fernando Gomez-Benitez	*FGB*										
14. Gene Gowdey	*GG*										
15. Gary Harrell	*GH*	P									
16. Brad Hume	*BH*	P									
17. Sam Kaplan	*SK*	P									
18. Gene London	*GL*	P									
19. Carmen Madríz	*CM*	E									
20. ~~Michael Meehan~~	*MM*	—									
21. Allen Meyer	*AM*	P									
22. Jim Mitulski	*JM*	P									
23. Gregory Neumark	*GN*										
24. Stephan Oxendine	*SO*										
25. Wayne Peace	*WP*										
26. Ken Pearce	*KP*	P									
27. Alissa Riker	*AR*	P									
28. Susan Shea	*SS*	P									
29. Janis Takamoto	*JT*	P									
30. Bob Teague	*BT*										
31. Jose Villarce	*JV*	P									
32. Robert Whitford	*RW*										
33. Mary Jane Wood	*MJW*	P									
34. Karen Wuopio	*KW*	P									

HIV Health Services Planning Council

City Hall, Room 201 1 Dr. Carlton B. Goodlett Place

June 25, 2001 4:30 PM

AGENDA

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I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 5/21 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:39 PM**
VI.	**Public Comment**	**4:43 PM**
VII.	**Reports**	
	• *Training: Goals and Objectives*	**4:47 PM**
	- Jessica Wolin, DPH-Population Health & Prevention	
	• *Presentation on Data from Reggie*	**5:15 PM**
	- Rani Marx, DPH-Health Services Research	
	• *Presentation on Congressional Black Caucus Minority AIDS Initiative*	**5:45 PM**
VIII.	**Break**	**6:00 PM**
	• *Presentation on Case Management, Peer Advocacy & Treatment Advocacy*	**6:10 PM**
	• *Presentation on Integrated Service Programs*	**6:40 PM**
	• *Discussion/Meeting Feedback*	**7:10 PM**
IX.	**New Business**	**7:25 PM**
X.	**Adjourn**	**7:30 PM**

Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Thurs	6/21	Prioritization Organizing Comm.	25 Van Ness, 5th fl. Conf. Rm.	5:30 – 7:00 PM
Thurs	6/21	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	6/25	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	6/27	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	6/27	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	6/28	Prioritization Organizing Comm.	25 Van Ness, 5th fl. Conf. Rm.	5:30 – 7:00 PM
Mon	7/9	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Thurs	7/19	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	7/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

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Housing Committee

Meeting Date: June 06, 2001

Meeting Place: 25 Van Ness Ave., Room 330-A

Members Present: Brad Hume (Chair), Ali Riker, Margot Antonetty, and Jose Villarce.

Others Present: Chris Callandrillo, and George Simmons (CCASF); Wolfgang Stuwe (DPH); Amy Cunninghis (SF AIDS Foundation); Jennifer Oberly (SF Redevelopment Agency); Beverly Karratz (Lutheran Social Services); Steven Feeback, and Christopher Murphy (minutes).

Next Meeting: Wednesday, June 27, 2001, 25 Van Ness, Room 330-A. 3:00-5:00 PM

Introductions

Announcements

Brad Hume announced that *Hazel Betsey* is resigning from the Council to devote her time elsewhere. On Tuesday, June 12th there is a meeting at the Seneca Hotel with the Board of Supervisors and it will guest fees and other issues in the SROs. Additionally, Brad distributed copies of the SRO Investigative Report that was produced by the Board of Supervisor's SRO Task Force. *Margot Antonetty* pointed out that the report was the first survey ever done on families living in the SRO hotels. It is hoped that it will produce some results, including other housing options. *Brad* continued with a questionnaire that the PWA Caucus has devised concerning consumer attitudes about services. He distributed copies to providers present at the meeting and asked that they distribute and collect them among clients. Instead of the meeting on July 4th, the next Housing Committee meeting was scheduled for June 27th. Prioritization would be the focus of the meeting. *Amy Cunninghis* said that information has gone out to clients about the change in administration of the Housing Wait List. The letter has resulted in quite a number of calls to SFAF. The change will take place on July 1. *Ali Riker* asked how the cleaning-up process has been going for the HWL. She was told that over 5,000 people out of about 7,000 total on the list have updated information. The transition to DPH administration is in process. In the future, the HWL will be re-opened in order to recruit particular populations, such as youth or families, for housing opportunities.

Update on Emergency Housing

MA gave another update and passed around a document entitled "Changes in the HIV/AIDS Emergency Housing System: Summary Description." It provides once again the rationale for changing from emergency vouchers to a coordinated system of respite beds, longer-term housing units in renovated buildings, and a block of master-leased rooms in a SRO for emergency use. The report includes a chart/summary of the four different sites as well as the providers, the number of units for referral by other HIV providers, the length of stay, and the eligibility requirements *(see attachments)*. She said her office was anticipated some construction delays at the Star Hotel in the Mission. The Contractor walked off the job. The situation is being monitored by DPH and a new Contractor is starting work.

Prioritization

Brad explained the meeting process and the background on Prioritization. The Housing presentation is scheduled for July 9. *MA* provided a refresher to the group about how implementation and prioritization are separate concepts. She reviewed the past Council Prioritization to examine the priorities that had been accomplished or implemented or it had been decided that nice ideas didn't necessarily make for achievable results. She did an implementation evaluation concerning the 15-25 priority items that had been identified last time the Council went through this process. These priorities led directly to the efforts

at renovating two buildings and blocking out 20 rooms for emergency needs on the part of HIV clients. After review, the work group of Brad, Catherine and Margot formulated the projects currently being worked on into a list of possible priorities, or objectives, for the upcoming year. The recommendations to the Council will be more focused and will not be in the form of a grid. This Committee will make the presentation about Housing Services, with the help of the Program Managers (Margot, Daisy and Wolfgang). The group decided to focus on what the specific priorities were going to be. It was felt that the priorities would fall into three categories: 1) Maintain current housing stock; 2) Keep people who are housed currently, in their housing; and 3) Help people get into housing. There was a great deal of preliminary discussion on specific objectives within those three categories.

Adjournment

CHANGES IN THE HIV/AIDS EMERGENCY HOUSING SYSTEM
SUMMARY DESCRIPTION
June 4, 2001

Background

Approximately two years ago, a broad-based working group of HIV/AIDS advocates and service providers began a series of meetings to discuss potential changes to the HIV/AIDS emergency housing system. The discussion was initiated based on the recognition that the existing emergency housing system had several major limitations including: 1) the poor conditions of the scattered-site SRO housing units available for emergency housing; 2) the current structure has the unintended effect of encouraging owners to continue the illegal practice of "musical rooms"; and 3) outcome data regarding the emergency housing system indicates that the program has not had much success in improving housing stability for homeless people with HIV/AIDS.

The recommendations reached by the working group can be summarized as follows:

- The use of scattered site SRO housing with no on-site services should be discontinued.
- In order to achieve meaningful assistance and work toward housing stability, length of stay should be increased to provide the opportunity for housing stabilization.
- Whenever possible, housing should include the availability of on-site services.
- Housing opportunities for people with HIV/AIDS should be leveraged by integrating such housing into other affordable housing initiatives.

These recommendations were discussed at the Housing Committee of the CARE Council and presented to the full CARE Council on several occasions and received broad support.

Implementation

The Department of Public Health's Housing and Urban Health Section (HUH) has been working to implement the changes recommended by the working group. Linking with other housing development work initiated by HUH, the opportunity presented itself to integrate HIV/AIDS funding being used for emergency housing into three different housing types. The chart on the following page summarizes the three housing types that will eventually replace the existing emergency housing system in the timeframe described below.

Timeline

The existing HIV/AIDS Emergency Housing System will continue through September 2001. On August 1, 2001, the 6 beds of HIV/AIDS Medical Respite will open at the Broderick Street RCF. On September 1, 2001, a block of 20 rooms of short-term emergency housing will become available. In November 2001, 16 long-term units will become available at the Star Hotel and in January 2002, 17 additional long-term units will become available at the Camelot Hotel.

Summary of New HIV/AIDS Housing Resources

	Block of 20 Rooms	Broderick Residential Care Facility HIV Respite Beds	Star and Camelot Hotels HIV Units
Site Description	A block of 20 rooms rented by DPH within one or two SRO hotels with 1 on-site coordinator	Two-story licensed Residential Care Facility with 24 long-term beds in 12 rooms and 10 short-term respite beds in 5 rooms	Two SRO hotels currently undergoing major renovation. Star is in the Mission; has support services and community space and 50 rooms for long-term housing. Camelot is in the Tenderloin and has support services and community space and 55 units altogether. 44 rooms are for long-term housing and 11 rooms are for respite.
Provider	Emergency Housing Coordinator (TBA)	Collaboration: Page Street Guest House w/Richmond Area Multi Services	Collaboration: Baker Places w/Tenderloin AIDS Resource Center (TARC), John Stewart Company (JSCO) and Lutheran Social Services (LSS)
Number of Units for referral by HIV providers	20 units	6 medical respite beds	33 units (16 at the Star; 17 at the Camelot)
Length of Stay	Each client will be allowed a maximum of four (4) weeks stay per year. Each stay may be from a minimum of 1 week to a maximum of 4 weeks.	Each client will be individually assessed. Maximum stay is 60 days.	Long-term/permanent housing.
Eligibility	▪ HIV positive ▪ Resident of S.F. ▪ Income is 30% of median or less ▪ Currently,chronically, or at risk of homelessness	▪ HIV positive ▪ Resident of San Francisco ▪ Currently, chronically, or at risk of homelessness ▪ A medical condition that is expected to improve within a maximum of 60 days ▪ Need to continue case management and medical services with referring agency	▪ HIV positive ▪ Resident of San Francisco ▪ Income is 30% of median or less ▪ Currently, chronically, or at risk of homelessness; incl. past utilizers of AIDS Emergency Housing ▪ Participation in 3rd party rent payment

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Membership Committee

May Report

Meeting Date: May 18, 2001

Meeting Place: 25 Van Ness Ave., Room 330-A

Meeting Time: 5:30 to 7:00 PM

Members Present: Ray Combs, Mark Dunlop, Carmen Madriz, Greg Neumark, Ken Pearce (Chair), and Janis Takamoto.

Others Present: Steven Feeback, minutes; and Laura Thomas, DPH-HHS.

Next Meeting: Thursday, June 21, 2000, 25 Van Ness, Room 330A, 5:30-7:00 PM
Meetings will generally be held on the 3rd Thursday of each month.

Introductions

Status of Nominees and Members with Terms Expiring

Ken Pearce talked about how long the Council nominees had been pending Mayoral appointment. He also listed the members who have terms expiring during the upcoming months of July, August and September. It was decided to send letters and the new nomination form (with their old information attached, if their prior nomination form is on file). Old members up for re-appointment may fill out just the first half of the nomination form if they would prefer. The cover letter should re-emphasize the time commitment.

New Nomination Form

Members requested further changes in the application, especially with the demographic information. There was discussion about defining a consumer of services as someone in care for HIV disease and receiving services (funded under Title I) in the past year. ADAP was included in the definition. It was decided to insert an additional question about services received.

Analysis of Current Membership and Areas of Representation

Laura Thomas talked about the Council currently having a lower than usual percentage of women members, particularly HIV+ women. By race/ethnicity, the numbers on the Council are fairly close to matching the HIV prevalence percentages. Currently, the percentage of HIV+ is 55% out of the total and about 34% unaffiliated consumers. The diversity of the HIV+ group is fairly good, but some historically under-served populations are under-represented on the Council. More unaffiliated consumers are needed. It was recognized that the percentages that form a statistical profile of HIV prevalence are somewhat different from the percentages we would find in a statistical profile of the consumers of HIV services. If we knew the exact statistical profile of consumers, those percentages could be applied to the Council's membership. But, the Membership Committee does not know the precise numbers in each and every demographic category among the consumers of service.

Recruitment of Members

Now that the Council is in the period of Priority Setting, some expressed the view that it is not the best time to put high energy into nominating more new members. It would be better to get the current nominees appointed and the membership solidified through orientation, training and mentoring through the period of Prioritization. *Greg Neumark* called for the development of an outreach plan, utilizing publicity information, organized recruitment and general public relations. He said the Committee needs to know how much of a budget it has for such an outreach plan. He wanted to generate higher numbers of applications submitted. *Mark Dunlop* also backed the idea of a Recruitment plan--something the Committee can ask the Council to

support. *KP* said the Council's help would be minimal any way, so the Recruitment plan would end up being an effort of the Committee. *GN* gave strong support for development of this plan, desiring to spend more of the meeting time on that topic. He talked about his idea to get more of the Council Support budget allocated to support the Recruitment plan. At this point, it was not clear what the Council Support budget provided. It will be voted on at the next Council meeting.

Recruitment Budget

KP said he had received an email communication saying that the current figure was about $2,000 in the budget for outreach and recruitment. *GN* said he would be requesting additional dollars. He wanted $7500 to be added. *Mark* asked Greg to draft an overall plan and present it at the next Membership Committee meeting. *GN* responded that the basis of his plan is having people at outreach tables talking to consumers about the Council and distributing a brochure in a more personable manner. Some unaffiliated consumers could earn minimal income this way (being paid for outreach consulting). This may end up removing a barrier to participation for a few Council members. *KP* knew that there were some unaffiliated consumers such as himself, who would not want to be paid. He wanted a philosophical discussion about the ethics of using some of the Council's overall budget for new member outreach. *GN* countered that the worse appearance is associated with paying Consultants $100 per hour. Everyone agreed that some time during the next meeting will be devoted to this discussion.

New Member Orientation

KP asked staff to assist Bob Teague with getting good attendance at the upcoming session.

Outreach brochure

Janis Takamoto passed around copies of a draft brochure that she had put together as a basis for further discussion and to be included in the outreach plan. *KP* asked members to review this draft in preparation for further discussion at the next meeting.

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HIV Health Services Planning Council
Prioritization Organizing Committee

June Report – 6/14

Meeting Date:	Thursday, June 14, 2001, 5:30 – 7:00 PM
Members Present:	Cecilia Chung and Gary Harrell, PWA Caucus Co-Chairs; Catherine Geanuracos, Council Co-Chair; Wayne Peace and Robert Whitford, PWA Caucus Representatives.
Others Present:	Celinda Cantu, Joseph Cecere, Marshia Herring, Hilda Jones, David Macias, and Laura Thomas, DPH; plus Steve Feeback, minutes; Edward Patterson and Mjay Sanders, Consumers/Council nominees.
Next Meeting:	Thursday, June 21, 2001, 25 Van Ness, Room 330, 5:30 – 7:00 PM then Thursday, June 28, 2001, 25 Van Ness, Room 330, 5:30 – 7:00 PM

Call to Order & Introductions

Feedback from last Council Meeting

Laura Thomas shared some Email feedback received from members following the June 9 Council meeting. Generally, members felt this one went better than the previous one. There were some complaints about the utilization of time during the presentations. There was some disagreement about the demographic data presented. *Wayne Peace* requested more information on who is being served and the unmet need. *Cecelia Chung* said data was interesting but she wants to know more about the actual services. *Susan Shea* said the crucial questions are what is the Council paying for and who is getting the services. Some members are getting a foundation about the service system. The previously agreed upon questions would continue to be used. The presenters should very definitely answer the questions, including the potential of other funding sources for the particular category. The format is going to be basically the same. It should only take one provider to present. It should be clear that multiple presenters should not be going through the same full set of questions. We are still fine-tuning this process.

Preparation for next Council Meeting

Council members are the best people to work with the contractors and presenters in order to get them to utilize their time allotment in the most efficacious manner. *Mjay Sanders* said he appreciated the materials handed out. It was decided to move the presentation on Client Advocacy, Transportation and Respite Care to the July 9 meeting. *Laura Thomas* and *Susan Shea* will meet before next week's Prioritization meeting to discuss how to make optimal use of the time schedule.

Consumer Input

Cecilia Chung detailed the elements of a plan developed by a work group of the PWA Caucus. It includes a survey now being distributed. There was a question about the Council Support budget and the amount available for Consultants. Some members felt that a Consultant would be very useful to the process of data-crunching on the survey now being circulated. The timeline is very compressed because the Caucus's presentation is scheduled for the July 9 meeting as well. *Catherine Geanuracos* said she would get a clear explanation about the available budget.

Focus Group for PLWH not in care

Laura Thomas said that it was scheduled and participants were being recruited.

Minutes, June 25, 2001 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at next meeting

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I. Call to Order
4:30 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda was reviewed and approved after minor modifications.

VI. Review and Approval of Minutes
5/21/01 Council Meeting Minutes – several corrections and editorial changes were requested. It was then moved to adopt the Minutes. By voice vote, the Council Meeting Minutes were unanimously approved.

V. General Announcements
Catherine Geanuracos welcomed newly appointed members and applauded *Cecelia Chung's* efforts for making this year's G/L/B/T Pride Celebration a success. *Jim Mitulski* welcomed *Richard Bargetto* back from his three-month leave of absence, mostly spent in Italy, and thanked *John Rosenzweig* for his work filling in for Richard. *Margot Antonetty* announced plans to present more information about the housing subsidies to the Board of Supervisors, with assistance from the San Francisco AIDS Foundation. The use of proxy forms was briefly mentioned. Acceptable use of a proxy holder is only for reasons related to illness. *Wayne Peace* appointed *Rob Whitford* to be his proxy. *JM* also announced that several journal articles were suggested reading (by Sam Kaplan) and could be copied by staff for those that wanted them.

VI. Public Comment
Paul Causey, Executive Director of the Tenderloin AIDS Resource Center, announced that the grant award for the Bridge Project had been renewed for another three years. He also spoke on behalf of the HIV and AIDS Provider Network (HAPN), expressing his appreciation to the Council for the work involved in the Prioritization process and letting Council members know that they should feel free to stop by agencies such as TARC in order to learn even more about the service system. *Renee Cyprien,* Program Coordinator from Transcending, stated that she hopes that more funding will be made available to the transgender community. *Reverend Greg Richardson,* spoke as a member of the People of Color Committee, the NAACP, and BAYPAC. He is also a board member and parliamentarian of CATS and works with North Beach Public Housing. He stated that these organizations will be watching what the Council does and he intends to advocate for the African-American community as well as other disenfranchised populations, such as transgenders. He referred to the experimentation done on Black citizens under the guise of treating syphilis. He stated his interest in working with the Council to ensure that the needs of the African American community are adequately addressed.

VII. Reports

VIII. Training: Goals and Objectives
Laura Thomas introduced *Jessica Wolin,* from DPH-Population Health and Prevention. Jessica stated that goals and objectives are a way of saying where you want to go and how you want to get there. Then the Council can know if it achieved what it set out to do by evaluating at a later date. A goal broadly defines what you want to achieve. A goal is not written to be measured nor is it time sensitive. Objectives describe how you will achieve specific outcomes. When put together, the objectives will result in the achievement of the goal. An objective should answer the questions: Who will be affected; What will change; How much change will occur; and by When will it happen. She recommended

answering all those questions when formulating objectives. She described two types of objectives: process objectives and impact objectives. In process objectives, the process is the outcome. It describes a process or activity undertaken by those implementing a program. Impact objectives describe what result will take place for people because of a program (for example increased math scores). She reviewed a hypothetical Priority activity, then asked the Council to develop its own Priority. Someone suggested Housing as a Priority area. The Goal was to have all people with HIV in housing. One objective was to see an increase in the City's Housing Budget by 10% by a certain date. Jessica told the Council that they needed to pick specific objectives that can answer: by how much, what, who, and when. She said that a rule of thumb when picking objectives was the acronym **S.M.A.R.T.**: **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime sensitive. *CG* said that HRSA wants outcomes to be written in terms of specific medical outcomes, and that the Council should keep this in mind when creating objectives. An example was that it is not sufficient to seek an outcome of greater access to health care. It is better to say what greater access will achieve in terms of a change in medical condition. It is best not to state the housing needs of clients as a set of objectives related to shelter, but rather as objectives that can be translated into medical outcomes. Percentage increases or decreases imply that there is a known starting point, or baseline, from which to make those comparisons. Sometimes, objectives must take the funding picture into consideration, in order to be realistic. Planning and budget must be coordinated. Objectives have a way of crossing over each other and it is therefore important to be concise and clear. This planning process is intended to capture on paper the clear objectives of the Council. *MJS* asked about the Council's prior history with goals and objectives. He wondered if there was accountability for those goals and objectives enunciated in prior years' grant applications. He was told by Laura Thomas that each year's grant application does not need a repetition of prior year objectives and an accountability for the achievement each objective. Instead, there is a summary or progress report about prior year objectives. It's written as a narrative about the preceding year, not as the identical format with a listing of objectives.

IX. Congressional Black Caucus Minority AIDS Initiative

Susan Shea asked that questions about presentations be reserved until the end. She referred everyone to the list of questions prepared by the Prioritization Organizing Committee (POC) in order to help presenters prepare. She thanked the AIDS Office Program Managers and service providers for their active participation in the Prioritization process. She said that this would be the first of several presentations in this meeting, and the POC had been assisted by Mjay Sanders as liaison from the Planning Council. *MJS* introduced *Marshia Herring*, the Program Manager, who presented her report in written form and introduced the provider representative, Dr. Yvette Flunder from Ark of Refuge. The project she supervises is one that serves primarily African American transgenders, particularly male-to-female transgenders. They have become aware of the high numbers due to increasingly accurate record keeping and a recent focus on this community. The most urgent unmet need is in the area where HIV treatment overlaps hormone care. She stated that transgender clients of color are forced to choose between antiretroviral therapy and hormone therapy. When faced with this choice, the higher probability was that clients would choose the hormone therapy. The clients have recommended that hormone therapy and antiretroviral therapy be made available at the same location from the same provider. There has been a 15% increase in homeless people with HIV disease or AIDS. The community with whom she works need greater stabilization in their lives, most especially in the area of housing. She said that primary medical care must be delivered with greater sensitivity to the needs of transgender clients. Transgender individuals in San Francisco will not receive primary care where they feel threatened. She said that the community needs a place to call their own—a provider and a location. Clients suggested to her that a late night facility be opened where they can hang out, keep their medications secure, and access other personal services. What is the role of treatment/peer advocacy in helping clients access and maintain primary care? She said that information has to be made available and linkages have to really function. Trust is a key element for transgenders. Access to clinical trials of drugs would benefit the transgender community as well. Service providers are not reaching IV drug users, those with mental health issues, public housing recipients, and heterosexual men having sex with

transgender people who do not identify as homosexual. When dollars are re-directed from one service to another, it destabilizes a continuum of care. When funds change from agency to agency, clients have to chase their care needs around the city to find out where the care went. The program may re-emerge somewhere else, but the cost of starting up operations. This is expensive and it takes away from the actual delivery of services. She concluded that the major need is for a safe space with auxiliary services, such as job training and start-up skills for entrepreneurs. Skills training would assist in the stabilization of a client's life, thus enabling them to pursue medical treatments. *Miss Major,* a peer advocate for the Transcending Program at the Ark of Refuge, reiterated most of the aforementioned points and talked about the importance of transgender staff working directly with transgender clients. She strongly urged that staff be more sensitive to who transgender people are because sarcasm drives HIV-infected transgender people away from treatment. So many transgenders are struggling with their own particular set of issues related to gender identity and how to cope with discrimination. The choices that their clients face are difficult ones. They need support.

Ron Strangerhorse and *Christopher Gomova*, Peer Advocates at the Native American AIDS Project spoke on behalf of the treatment and peer advocacy program operated by NAAP. *Ron* highlighted a client who sought help from them: he was homeless and newly diagnosed with HIV, without any HIV services or case management. Ron explained that this client felt this was the first time he had been helped to feel at home by any agency. This man is in recovery and has come a long way in his battle against HIV, finding himself now in a position of wanting to give back to the community. He has seen this pattern in other clients who have sought treatment for drug or alcohol dependency. *Christopher* suggested that Native Americans are being served in their agency by peer advocates and require a sensitive treatment advocate. He suggested that indigenous people have to deal with culturally insensitive staff in other agencies. The result can be that medical conditions get worse before appropriate treatment options are provided. In their program, the spiritual dimension and traditional healing practices are fully integrated into the other aspects of treatment support.

X. Presentation on Data from Reggie

Susan Shea introduced *Rani Marx,* of the DPH-Epi & Evaluation Section. She started by explaining that Reggie is the centralized and computerized client registration database. This project was begun in 1993 with the objective of eliminating the paperwork duplication and running around that people ill with AIDS had to do in order to register at multiple agencies for each service received. It was named after Reggie Williams, one of the AIDS pioneers and community activists in San Francisco. The concept is that a client may go to one AIDS agency and register with the entire system. This single registration would go into Reggie and from there be made available to any other provider that the client may seek out. It is the only way for the DPH to count clients individually and to know what services are being utilized. It may turn into a valuable evaluation tool, both for administrators and agencies.

She briefed the Council on the statistics for Reggie as of the year 2000. A total of 9,436 unduplicated clients received services at one or more agency during 2000; this represents an estimated 82% of clients receiving services in SF. There are now 50 Reggie agencies, which represents 96% of the agencies in SF. Not every client encounter gets entered into the system, especially in primary medical care, mental health, dental care and substance abuse treatment. She presented the overall demographic profile of the clients in the database. She said that 93% of clients choose to share their statistical information and their medical information across agencies. There is almost a 50/50 split between those who report having HIV and those reporting an AIDS diagnosis (plus some missing information). She covered categories such as risk factors of clients, age, race/ethnicity, gender, annual income, current living situation, health insurance, and primary source of health care. She also highlighted medical information such as most recent CD4 count, most recent viral load, and self-perceived health status.

The next set of charts was correlations relating to housing situation. The clients who were homeless during the past year were compared with the clients who reported more stable housing. The homeless

population was significantly more likely to report health status in the poor or fair categories, while clients with housing were significantly more likely to report health status in the good, very good or excellent categories. Clients were asked about choices between medical care, food, clothing and shelter. It is clear that the homeless were much more likely to sacrifice medical attention in favor of other basic needs; and when money was needed for health care other basic needs got sacrificed. People who were homeless were significantly more likely to go to the ER because they could not get regular doctor visits and to report two or more days of missed medications due to a lack of money. She offered a summary profile of homeless clients in Reggie, though this is preliminary data. She said that while all of the data had not been evaluated, there is a particular relevance in comparing those that are stably housed to those that are not and the homeless to the other unstably housed. She also gave a summary of findings on service usage, related to race/ethnicity and to gender. She expressed an uncertainty about this preliminary data and said that further study was called for. She said there may be underlying explanations for these patterns in service usage. She also listed the limitations of the Reggie database and the conclusions from her research. She was asked what kind of training staff get in conjunction with the Reggie system when a new agency comes online. Only in the last year has Reggie been backed by the necessary mandate in order to allow DPH to create standards for such things as staff training. Alberto Martinez, the Project Director for Reggie, explained how the system works with individual agencies when it is "rolled out." The training is extensive, but some agencies have not yet entered full information for their clients. John Conley explained for the benefit of newer Council members that neither San Mateo County or Marin County take part in the Reggie system. She was asked the budget for Reggie, a topic with much history. At this point, no funding is provided from funds allocated by the CARE Council. Rani Marx said that the project was successful in obtaining this year's budget from the Dept. of Public Health ($500,000). Additional funding had come forward for training and software. There is no assurance of stable funding after this fiscal year. She said the greatest challenge was to improve the quality of the data. *SS* added that while the Council has not prioritized any of its funding for Reggie, the Council does depend on the data in order to have the information that is necessary to include in the annual grant application. It is important for the Council to be aware of what is happening with the Reggie project.

XI. Break

XII. Case Management/Peer Advocacy/Treatment Advocacy

JM called on *Brad Hume* to make an announcement about housing subsidies and the need for letters on this topic to be sent to City government, specifically the Board of Supervisors, in an effort to prevent the further erosion of housing assistance for PLWH. *SS* introduced the Program Manager for this set of services, *Hilda Jones*. She distributed written information to augment her presentation. She began by asking how many Council members had participated in the prior Prioritization process. A small number responded affirmatively. She referred to the overall chart of service categories and budget allocations for each category in order to highlight the sections on Case Management and Integrated Case Management (I1 and I2). Her presentation began with definitions of Case Management, Peer Advocacy, Treatment Advocacy and Integrated Case Management. She then reviewed the providers in these categories and sub-categories. She also talked about the extensive inter-connection of these services and other sub-categories that are listed under health care, particularly integrated service programs (ISPs) and Treatment Adherence. That is because Case Management takes place in a variety of locations and care settings: Primary Care facilities, a Mental Health provider a Residential Substance Abuse provider, housing programs, and Multi-service providers. She referred to other funding sources such the General Fund and State funding, which augment CARE funding. Her handout also covered important topics such as Units of Service, Costs per UOS, Target Populations, Unduplicated Clients and Client Demographics. She closed with Recommendations.

Next, *HJ* introduced *Rachel Matillano,* representing one of the programs funded under the Integrated Case Management sub-category. *Ms. Matillano* is from the Asian and Pacific Islander Wellness Center,

but was introduced to speak about the category in general. *RM* said that psychosocial services have been a part of the continuum of care for a long time, before the ISPs existed. At one time these services were referred to as Early Intervention. She said she wanted to answer the guideline questions that were developed by the Council. She said that the most urgent unmet need is to adequately respond to clients who are in crisis, especially with their housing situation. There is a need for specific, individualized advocacy services for clients with a housing crisis. Many clients are not eligible for the housing programs that currently exist. She mentioned the need for a kind of brokering on behalf of clients who need housing. Treatment adherence is also an area where there are needs due to the complexity of AIDS medications. Case Management/Peer Advocacy is frequently the main path for getting clients linked with primary care and keeping clients connected to the continuum of care. Many services are available in the single location or through close collaboration. That is the ISP model. Advocates encourage clients to continue treatment, ensure timeliness to medical appointments, and help create more access to the primary care provider. Peer advocates act as paralegals, para-financial managers, paramedics, and para-counselors in order to assist clients with basic needs and promote health care. An important role of peer advocates is to make certain clients gain and retain insurance eligibility. Advocates deal with everything that could possibly impact client's adherence to primary care and treatment. Peer advocates also are role models for clients. They also provide practical and emotional support. She provided a list groups that are perhaps not being reached by these services. She asked that the Planning Council review her general recommendations. *Hilda Jones* quickly added a word about the work now underway with regard to Standards of Care.

XIII. Integrated Service Programs (ISPs)

Rob Whitford introduced the presenters. *Tom Calvanese*, TARC's Deputy Director and former Council member, spoke first. He referred to the goals of serving populations in severe need and to do so in a way in which there is 100% access and 0% disparity in accessing primary care. This new category of service combined several of the existing services and the RFP process allowed the creation of new programs that have addressed a complex array of challenges and barriers being faced by people who have dual and triple diagnoses, as well as other related factors: poverty, homelessness, mental illness, and substance abuse. ISP's are inclusive of: Primary Care, Nursing, Mental Health Services, Housing, Case Management, Treatment Advocacy, and Peer Advocacy. Other ISP's also include Substance Abuse Counseling and Treatment, Transportation, Complimentary Therapy, Nutritional Supplements, and non-HIV specific services. The key to the success of these programs is that they place at the center of their services the unique needs of their clients.

Russ Zellers spoke next. He delineated the differences between Integrated Service Programs and Integrated Case Management. He said that both ISP and ICM are both integrated but have different scopes of service. He began by stating that an RFP or Request for Proposals was issued in 1998 for integrated services. The goal of integrated services is to expand access and to improve the health and quality of life for severe need target populations by providing multidisciplinary services through an integrated model of care that places primary care at the center of the service delivery system. Severe need populations are defined as very low-income individuals (including those who are homeless or marginally housed) who are multiply diagnosed and individuals outside the system of care. An integrated model was defined in the RFP as one where services are merged, coordinated or otherwise linked together to ensure the delivery of a comprehensive spectrum of care in a seamless manner to the target population. *RZ* explained that there are 6 ISP's in San Francisco one in the Tenderloin, two in the Haight, one south of Market serving Native Americans, one serving women, and one serving Asian and Pacific Islanders. There is a range of design and target programs that came out of the 1998 RFP. He displayed a map portraying the highest concentrations of HIV in the city and suggested that the ISP's are located in dispersed districts around the center of SF and able to serve high number of clients. He said that it was important to be aware that there are other models of integrated services that are funded through the AIDS office which are not technically ISPs: $2.3 million from CARE Title 1 funds multi-disciplinary services at Castro/Mission Health Center, Maxine Hall, and Tom Waddell. He cited

more examples (SF General, UCSF, Early Intervention programs at Mission Neighborhood Health Center and Southeast Health Center and other collaborations). He mentioned that such collaborations involving multiple agencies tend to take enormous amounts of administrative staff time and that contractual indirect and administrative funds do not cover these coordination activities.

Russ broke down the demographics of those receiving services. He stated that 75% are male, 58% of the client base is comprised of people of color compared to 44% of Reggie clients are people of color. He said that the ISPs are serving higher percentages of African Americans, Asians, Pacific Islanders and Native Americans, as well as more females and more transgenders. His conclusion was that the ISPs are reaching populations with severe need and serve as the entry point for some people who otherwise would not be in care at all. *RZ* touched on the average costs for units of service at ISPs. These figures reflected that ISP dollars are well-spent when compared with other service models and are well within the caps. He gave a summary of the distinct services within ISPs; his chart showed the percentages of total funds for ISPs that went into each of these distinct services. ISPs are important to reaching individuals "out-of-care." He listed several reasons for that, mainly involving ease of access and convenience in a non-institutional setting where fear can be minimized. The general recommendations he offered were to continue to refine the design of integrated services by facilitating information sharing meetings among programs, providing consultation on successful collaboration, and encouraging dialogue between programs and HHS staff. Additionally, continue to encourage strong links between ISP's and substance use, mental and dental health, and other services. Also, consider seeking funding for evaluation of the ISP model.

Carol Carbone, HIV Program Service Manager from TARC, was the next presenter. She gave a brief description of a client whose treatment has been successful because of access to an ISP. The client was a 60-year-old, a crack user, and a person who was also schizophrenic. A continuous cough brought him to seek medical attention. At that time he was diagnosed with pneumonia along with HIV and HepC infections. The mobile medical team evaluated this client while he was in the hospital. He was referred to TARC. He had poor experiences with medical and psychiatric care in the past. He got into Case Management and then primary care at an Integrated Service Program. She went on to describe the treatment course that this man had. For more than a year, he has been in care and making incremental steps. The ISP model can take some of the credit for this. At two different points, he withdrew from care, but with the help of the mobile team (nurse and peer advocates), he was brought back into primary care. He had refused some forms of treatment at a time when his CD4 count was under 200 and had a very high viral load. After starting HIV medications, his viral load became undetectable and his CD4 count went up to over 500. Continuing to work with a treatment advocate, he also agreed to try medications for his mental illness, and he reports great success with this regimen. This client is continuing his course of treatment and care.

Barry Lawlor from St. Mary's Hospital spoke next. Knowing that the Planning Council is unlikely to augment funding, he advocated using the power that they hold to encourage the DPH to integrate HIV care with mental health services and substance abuse treatment services. He talked about how the ISPs break down barriers to care. The core of ISP care is primary care. The other services help insure that clients stay in primary care. If the hassles of attempting to receive treatment are eliminated, then the likelihood that the most severe need people will stay in care is greatly enhanced. Integrated primary care reduces barriers. *BL* felt that demographic information showed that those most urgently in need are the people being served. However, he feels that a more concentrated mobile effort could further assist those requiring care by picking them up and actually delivering them to various programs throughout the city where they could receive care. He cited the need for outreach workers and innovative outreach techniques. He asked that funding not be shifted because that would endanger the integrity of the services now provided by ISPs. He cited good outcome measures in advocating the effectiveness of this service model. He gave a few general recommendations. He stated that the ISPs planned on holding meetings every other month to improve the lines of communication among the

providers. He said other funding sources (state, federal, private foundations) are already being utilized in order to fund the level of service now being provided. Housing is a fundamental need, and this is the area where additional resources are clearly needed. Again, he expressed the sentiment that a person cannot heal and live a stable life without housing. Housing is health care.

XIV. Meeting Feedback

Susan Shea said that communication via email with Council member input would continue. She spoke briefly about the goals and objectives that the Council needs to develop with the help of a facilitator. *SS* said that rollover dollars or Unfunds was going to be a topic during the last three meetings of Prioritization. Comments from Council members were positive concerning the meeting format and the information provided by speakers. Opinions varied about the most valuable components of the questions being addressed by service providers. One member requested that Council members eliminate the sidebar conversations and chatter during meetings. Another member requested clarification when transgender clients were mentioned, due to the reality that services would be different in the case of clients who are male-to-female and those who are female-to-male.

XVII. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

June 25, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P									
2. Hazel Betsey	*HB*										
3. Toni Butler	*TB*	P									
4. Jeff Byers	*JB*	P									
5. Bart Casimir	*BC*	P									
6. Cecilia Chung	*CC*	P									
7. Raymond Combs	*RC*	P									
8. John Conley	*JC*	P									
9. Larry Cruz	*LC*	P									
10. Mark Dunlop	*MD*	P									
11. Gregory Edwards	*GE*										
12. Donald Frazier	*DF*										
13. Catherine Geanuracos	*CG*	P									
14. Fernando Gomez-Benitez	*FGB*	P									
15. Gene Gowdey	*GG*										
16. Gary Harrell	*GH*										
17. Brad Hume	*BH*	P									
18. Anthony Huynh	*AH*	P									
19. Sam Kaplan	*SK*	P									
20. Gene London	*GL*	P									
21. Carmen Madríz	*CM*	P									
22. Michael Meehan	*MM*										
23. Allen Meyer	*AM*	P									
24. Jim Mitulski	*JM*	P									
25. Gregory Neumark	*GN*										
26. Stephan Oxendine	*SO*	P									
27. Edward Patterson	*EP*	P									
28. Wayne Peace	*WP*	P									
29. Ken Pearce	*KP*	P									
30. Alissa Riker	*AR*	P									
31. M.Jay Sanders	*MJS*	P									
32. Susan Shea	*SS*	P									
33. Janis Takamoto	*JT*	P									
34. Bob Teague	*BT*										
35. Jose Villarce	*JV*	P									
36. Robert Whitford	*RW*	P									
37. Mary Jane Wood	*MJW*	P									
38. Karen Wuopio	*KW*										

HIV Health Services Planning Council

City Hall, Room 201 1 Dr. Carlton B. Goodlett Place

July 9, 2001 4:30 PM

AGENDA

I.	**Call to order**	4:30 PM
II.	**Roll Call**	4:32 PM
III.	**Review and Approval of Agenda**	4:34 PM
IV.	**Review and Approval of Minutes**, 6/11 — **VOTE**	4:36 PM
V.	**General Announcements**	4:39 PM
VI.	**Public Comment**	4:43 PM
VII.	**Reports**	
	• *Membership Committee* — **VOTE**	4:50 PM
	• *Presentation on Housing*	4:55 PM
	- Housing Comm. and DPH Housing staff	
	• *Presentation on Client Advocacy/Financial Services*	5:25 PM
	- Money management, benefits counseling & emergency financial assistance	
	• *Presentation on Client Advocacy/Legal Services*	5:45 PM
VIII.	**Break**	6:00 PM
	• *Presentation on Transportation*	6:10 PM
	• *Presentation on Day and Respite Care*	6:20 PM
	• *Needs Assessment Data*	6:30 PM
	- Johanna Crane, REACH	
	• *Report-back from Phoenix meeting sponsored by HRSA*	6:50 PM
	• *Unfunds Process Report by Susan Shea*	7:05 PM
	• *Discussion/Meeting Feedback*	7:20 PM
IX.	**New Business**	7:29 PM
X.	**Adjourn**	7:30 PM

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Wed	7/11	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	7/12	Prioritization Organizing Comm.	25 Van Ness, Room 330	5:30 – 7:00 PM
Thurs	7/19	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	7/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	7/30	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	8/1	Housing Committee	25 Van Ness, 7th fl, Room 701	3:00 – 5:00 PM
Wed	8/1	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	8/2	Prioritization Organizing Comm.	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	8/13	HIV Health Services Planning Council	City Hall, Room 421	4:30 – 7:30 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

June Report - PWA Caucus Meeting

Meeting Date:	June 6, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:30 PM
Members Present:	Cecilia Chung (Co-Chair), Gary Harrell (Co-Chair), Ray Combs, Rob Whitford, Wayne Peace, Brad Hume, and Jose Villarce
Others Present:	Edward Patterson, Council nominee and consumer of services. John Rosenzweig, HIV Consumer Rights Advocacy Project. Lucky Choi, consumer. Eric Ciasullo, DPH-HHS. Steven Feeback and Christopher Murphy, minutes.
Next Meeting:	Wednesday, June 27, 2001, 25 Van Ness, Room 330-B, 5:30-7:30 PM

I. Announcements

June 12th at the Seneca Hotel there will be a meeting with some members of the Board of Supervisors pertaining to SROs. Also on June 12th will be the dental focus group to discuss dental care for PLWH. The focus of the group will not be how to access services but rather the types of services that are authorized under the CARE dental program and how to make services more available for clients.

II. Housing Committee Report

Brad Hume presented recommendations that the Housing Committee was then considering in preparation for its presentation to the Planning Council during prioritization:

1) Expand the number of rooms available for emergency voucher blocks. 2) Increase the resources for the master leasing of buildings. 3) Educate and train staff working with active users. 4) Provide appropriate staffing to respond to the higher level of needs in the harm reduction environment. 5) Advocate for increased building code compliance and enforcement by gaining a Council seat on the SRO Task Force. 6) Increase legal advocacy for eviction prevention. 7) Ensure existing stock of housing is not reduced. 8) Ensure all housing assistance programs include a strategy that focuses on shifting clients into or maintaining stable housing.

Brad said these would probably get further summarized. He asked if members of the PWA Caucus thought the Housing Committee was on the right track. Opinions and questions followed. It seemed like a difficult task to get a seat on the SRO Task Force. The amount of money that the Council allocates to emergency housing is relatively small. Only a portion of that funding goes toward SRO units. Nevertheless, there are large numbers of CARE services clients living in the SROs. The master leasing efforts and building renovations now underway are collaborative projects, utilizing a variety of funding sources and agencies. Minimal CARE money is going to the two buildings about to come online, the Star and the Camelot. PLWH will be getting a higher percentage of slots than the percentage of money the Council is contributing. The buildings are behind schedule, perhaps as late as November, due to extensive renovation and construction delays. Referrals will not be from the Housing Wait List. On an up note, Brad stated that the Redevelopment Commission had approved an allocation of $30,000 to the SFAF to help with the transition period from the voucher program to the block of 20 units. This and other transitions will be taking place over the course of the summer and fall. These will involve the shelters as well as the transitional and emergency housing. The

amount of emergency beds available each night may prove to be insufficient to serve the needs that are out there. Some members were dissatisfied that the funding and the housing slots may be "tied up" in the two renovated buildings. It was hoped that units do not sit empty while the need for emergency housing is so obvious. These buildings will be a big improvement over the conditions in other hotels, but they will only be able to house a small percentage of the people who need shelter and housing.

III. Report from the Consumer Rights Advocacy Project

John Rosenzweig presented four new cases that were resolved and eight outstanding cases that he was still trying to wrap up. The first of the four resolved cases was a man who had difficulty obtaining his security deposit upon his departure from Baker Places. He did finally receive a check. Two cases pertained to the Housing Wait List. One man was told that he was dropped from the HWL only to be located on inactive status. His name was re-activated and he is now awaiting placement. Another man raised a question about his position on the Housing Wait List because he lives at a Residential Care Facility with his service animal (this has been the subject of much controversy, even litigation). The policy is that once in stable housing, the resident has to give up the top position. The last case was a person who accessed the AIDS Emergency Fund for housing but did not stay the duration of the month that the check covered. She was having trouble getting the balance sent back to the AEF, where she would be able to access these funds for other necessities. This, too, got cleared up. *Cecelia Chung* thanked John for filling in for Richard in his absence. Two cases from the prior month also got resolved, one problem with notations in a medical record at UOP and a housing subsidy issue.

IV. The Questionnaire for the Caucus' Report on Consumer Input

Cecelia mentioned that the Caucus needed help in distributing the questionnaire seeking data for the PWA Caucus report to the Planning Council as part of the prioritization process. There was a question of who the consultant would be for the actual preparation of the data. Some members felt it was too difficult to identify an outside consultant and that the Caucus would end up doing it anyway. Others wanted to proceed with data collection and the search for a Consultant. *Eric Ciasullo* volunteered to assist in the location of a Consultant through the efforts of the AIDS Office and PRC. He stated that it would be advantageous to develop a job description and proceed to hire somebody to crunch the numbers delivered by the questionnaire since the money is apparently available. It was decided to have all of the questionnaires back to the Caucus or staff by Friday, June 22. *Cecelia* was going to continue to work with PRC on the focus groups. Eric was going to have a discussion with PRC about hiring someone to organize the data into a report.

V. Adjournment

HIV CONSUMER RIGHTS ADVOCACY PROJECT
1540 Market Street, Suite 301
San Francisco, CA 94102
Tel: 415.863.8131
Fax: 415.863.0831

PWA CAUCUS – MAY 2001 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Pending
2-	Dental	UOP	Quality of Care	Resolved
3-	Housing	Catholic Charities	Access to services	Resolved
4-	Mental Health	AHP	Access to Services	Pending
5-	Legal	SFAF	Access to Services	Pending
6-	Housing	Black Coalition on AIDS	Discrimination	Pending
7-	Case Management	TARC	Quality of Service	Pending
8-	Case Management	TARC	Quality of Service	Pending

1- Client claims that he not only received unsatisfactory services from UOP dental clinic, but also tha. after one year his dental needs have not been fully addressed. The client filed a grievance in the form of a memo addressed to the Advocacy Project, which was forwarded to UOP. UOP referred the memo to their attorney, and responded to the client's memo with a dismissal from the UOP program and a referral to Community Dental. UOP's attorney asserts that the memo was not a grievance, and insists that UOP has no further obligations to the client. The client, an attorney, wishes to prepare his own response to the attorney, and is in the process of doing so.

2- Client claims that he has been mistreated by staff and professionals at UOP over the past few years, and that inappropriate notations have been made in his dental charts regarding his behavior. Client believes these notations have damaged his reputation at UOP, and that he would be subjected to further mistreatment if he were to continue as a patient at UOP. Client filed a grievance against UOP regarding several alleged incidents of mistreatment and improper notations, and UOP has responded. Client was dissatisfied with UOP's response, and the Advocacy Project arranged a meeting among the client, UOP administration, and the Advocacy Project. The UOP administrator agreed that certain notations in the client's dental records were inappropriate, and added notes to the chart stating that the prior notes were inappropriate. The client wants the inappropriate notes removed from the record but has elected not to pursue the matter further.

3- Client claims that Catholic Charities denied him a housing subsidy because they could not reach him by telephone. Client has voice mail, but no telephone service. Catholic Charities staff left client a series of messages informing him he had qualified for a housing subsidy and asking client to call to set up an intake appointment. Client returned the telephone calls, but could not reach the person \ left the messages, and left a series of messages for Catholic Charities staff informing them when he

would be available to come in. When client finally reached the staff person by telephone, she informed him that the subsidy had been awarded to someone else. The client filed a written grievance on his own, then contacted the Advocacy Project for assistance. The Advocacy Project contacted Catholic Charities and arranged for the client to reapply for the subsidy under revised procedures. Client received the subsidy, which enabled him to pay his past-due rent, and is satisfied with the result.

4- Client claims that AHP created barriers to its services that amounted to a denial of reasonable accommodation. The client had requested a telephone intake due to severe fatigue and limited vision, and AHP insisted that he come to its office for three separate appointments before he was referred to a therapist, and then required him to wait four to five months for an appointment. Client feels that the therapist he was assigned to provided inappropriate counseling. According to the client, the therapist also refused to accommodate his request for a two week break in his therapy sessions, claiming it was AHP's policy not to allow such a break. The Advocacy Project is assisting the client in preparing a grievance addressing the issues raised by the client's experience with AHP.

5*- Client claims that SFAF created barriers to its services that amounted to a denial of reasonable accommodation. According to the client, who has severe fatigue and limited vision, the SFAF required him on two separate occasions to come to its offices for services that could have been provided over the telephone or at his home. When he arrived for these appointments, client claims he was required to wait 45 minutes for the first appointment and 1½ hours for the second appointment. The client also believes he was misinformed about the services to be provided at the second appointment, which he believed was for the purpose of meeting with an ALRP attorney to prepare a will and powers of attorney. The appointment was in fact with an ALRP staff attorney to do an intake for referral to a volunteer attorney within two to three months. The Advocacy Project is assisting the client in preparing a grievance concerning the SFAF's procedures. The Advocacy Project also contacted the ALRP to arrange for an expedited referral due to the client's medical condition.

6- Client believes that the Black Coalition on AIDS/Rafiki Housing Program/Brandy Moore House has denied him housing based on a staffperson's knowledge of his prior use of medicinal marijuana in another program. Client filed a grievance with the assistance of the Advocacy Project, and is simultaneously utilizing the grievance procedures of the Human Rights Commission. BCA responded, stating that the client had not done a housing intake. Client claims he did a housing intake, and is not satisfied with BCA's response. BCA has agreed to meet with the client and the Advocacy Project to discuss the grievance.

7&8- Clients, who are domestic partners, have a number of complaints about their case manager at TARC, primarily relating to his failure to get them into permanent housing, but also involving poor communications and failure to give clients food vouchers and housing vouchers. Clients believe they may have been discriminated against. The Advocacy Project arranged a meeting among the clients, the case manager's supervisor and the Advocacy Project in which the clients presented their complaints, and the TARC supervisor responded informally to some of their complaints and arranged to have the clients transferred to another case manager. The TARC supervisor wrote up a summary of their grievance and is in the process of preparing a formal response to their grievance.

NEW CASES

	Service	Agency	Issue	Outcome
1-	Housing	Baker Places	Security Deposit	Resolved
2-	Housing	HWL	Consistent Policy Application	Resolved
3-	Housing	HWL	Quality of Service	Resolved
4-	Housing	Restoration House/Ark of Refuge	Failure to Refund Rent	Resolved

1- Client's security deposit was not refunded to him when he left Baker Places. Baker Places claimed that a check was issued, but was lost in the mail. Client requested the Advocacy Project's assistance in obtaining his refund. The Advocacy Project called Baker Places and arranged for the check to be reissued and messengered to the client.

2- Client's position on Housing Wait List for subsidized housing was adjusted downward after the HWL learned that client had been permanently placed in Peter Claver. Client's placement in Peter Claver had previously been considered temporary due to ongoing litigation regarding the client's right to have his service animal live with him at Peter Claver. Client's right to have the service animal live with him at Peter Claver is now unrestricted, according to Peter Claver staff. The Advocacy Project confirmed with HWL staff that it is HWL policy to list individuals who have obtained permanent housing below those who have not yet obtained permanent housing, and explained this policy to client.

3 Client was contacted by the Housing Wait List in 1997 and told that he had one week to go to the Housing Authority to get his independent housing subsidy certificate. Client was ill with hepatitis at the time and did not respond. Client claims he later received a letter telling him he had been dropped from the HWL. Client contacted the Advocacy Project for assistance in filing a grievance. The Advocacy Project contacted HWL staff, and confirmed that the client was on inactive status, due to the fact that the HWL did not have any current contact information. The Advocacy Project arranged for the client to meet with HWL staff to provide updated information, and the client is now near the top of Housing Wait List for an independent housing subsidy.

4- Client requested the Advocacy Project's assistance in obtaining a refund of rent paid from Restoration House/Ark of Refuge. Client had arranged for the AIDS Emergency Fund (AEF) to pay one month's rent at Restoration House, but only stayed there for nine days. Restoration House did not refund the money for the pro-rata rent to the client's account at the AEF as promised. Advocacy Project contacted Restoration House, which finally sent pro-rata rent back to AEF and client has been informed that these funds are available if needed.

Referral Calls:	ALRP Services	2
	Positive Resource Center Services	1
	AIDS Emergency Fund Services	1
	SFAF Services	1
	UCSF Dental School Services	1
	Catholic Charities Services	1
	Total	7

* Duplicated Client

(Report prepared by John Rosenzweig & Richard Bargetto on 6/5/01)

Consumer Focus Group
June 26, 2001
25 Van Ness Room 330A

Summary

This community focus group was comprised of clients considered "most in need". Approximately 45 people attended the 1 ½ hour session. The following is a summary of clients' opinions regarding each service category. At the end of the focus group, each participant was asked to list the top three most important services for her/him. The order of the following service categories corresponds with the overall ranking done by the participants; i.e. Housing was #1, Primary Care #2, etc.

Housing

- System disorganized
- Concern over order of waiting list.
- Denied Services.
- Limited housing opportunities was noted as the greatest concern.
- Lack of stable housing prevents people from getting care, taking medication, etc.
- Limited scope of emergency funds and difficulty obtaining assistance.
- Perceived racial discrimination.

Primary Care

- Poor treatment of patients by staff.
- Unclear how to correctly gain access to care, such as who serves Medi-Cal, Medicare or Private Insurance.
- Penalties for tardiness to appointments.
- Rescheduling penalty for lateness to appointments.
- Difficulty finding primary doctors.
- Discrimination due to past behaviors.
- Lack of knowledge of how to change primary care providers.
- Perceived Racial Discrimination.

Food

- The general consensus was that the food programs in San Francisco are excellent.
- Restrictions in the amount of food stamps make the food banks necessary for survival.
- Quality of food could be better.
- Problems accessing services.
- Success of the programs is based on volunteers.

Substance Use

- Extremely important for sobriety.
- Sobriety assists in regularly taking antiretroviral.
- To ensure adherence to programs, patients should be required to pay for treatment.
- Should remain free to ensure attendance.
- Excellent care therefore, cuts should not happen.
- Very important to people with HIV/AIDS.
- Many transgender people rely on the counseling.
- Need more "street wise" outreach workers.

Legal Assistance

- Problems with accessing services due to lack of availability.
- Need for more direct advocacy when working with lawyers.
- Perceived Racial Discrimination.
- Better Training.
- Elimination of Case Managers.
- Not trustworthy.
- Necessary evil.
- Lack of personal connection.
- Need to improve cultural sensitivity.

Dental Care

- The truly poor do not have access.
- Services should begin on same day as enrollment.
- Delay in services due to wait for certification letters.
- Money for dental care is given to the wrong agency.
- Teeth pulled without replacements given.

Money Management

- More programs.
- Food and shelter initiatives should come before money management.
- Some agencies will not release money upon client's request.
- Very helpful for budgeting.
- The bridge between well being and poverty.
- All programs geared towards people with HIV are important.

Transportation

- Some modes inaccessible to the handicapped.
- Vans do not always pick clients up on time for appointments.
- Fast passes should be distributed to clients at the beginning of each month.
- Outer skirts of San Francisco not serviced regularly.
- Taxi vouchers should be easier to access.

Case Management

- Should not receive funding because any information may be obtained from the Primary Care provider and Substance Abuse Counselors.
- Perceived racial discrimination
- Need better training
- Too much duplication of services resulting in a waste of money.
- Eliminate case managers.
- Not trustworthy
- Necessary evil.
- . Lack of personal connection.
- Need better cultural sensitivity.

Common Themes

- All services are very important.

- Clients find accessing services difficult due to lack of knowledge of where to go, feelings of being disenfranchised from the service system, limited resources and length of time getting appointments.

- Clients do not know how to maneuver through the complex system of care and this is another barrier to accessing services.

- Clients often feel that service providers lack the necessary level of sensitivity to culture, substance use, etc. This makes clients feel uncomfortable and hinders them in accessing services.

- Clients voiced concerns over the lack of continuity between providers. Enhanced communication between different providers.

HIV Health Services Planning Council
Prioritization Organizing Committee

June Report – 6/28

Meeting Date: Thursday, June 28, 2001, 5:30 – 7:00 PM

Members Present: Cecilia Chung, PWA Caucus Co-Chair; Catherine Geanuracos Council Co-Chair; Brad Hume, Susan Shea, Jose Villarce, Mark Dunlop, Robert Whitford, Edward Patterson and Mjay Sanders.

Others Present: David Macias, DPH; Laura Thomas, HIV Health Services; plus Chris Murphy, minutes.

Next Meeting: Thursday, July 12, 2001, 25 Van Ness, Room 330, 5:30 – 7:00 PM

Call to Order & Introductions

Review of Agenda

Feedback from last Council Meeting
Laura Thomas gave an overview of feedback. She said that there were fewer comments than normal following the meeting that indicates that there was a lower level of frustration. There were complaints about the CBC presentation and the heading that they presented under. *MJay Sanders* volunteered to obtain feedback from the five different CBC Providers since there are very distinct from one another. Also, presenters should be conscious of time allotments and relinquish the floor when their time has elapsed to keep the meeting running smoothly. *Susan Shea* called for comments. *Rob Whitford* stated that said that there was miscommunication pertaining to the number of speakers per group and the actual number that appeared. *Brad Hume* mentioned that time management is still an issue with the Planning Council. He sighted delays in starting the meetings on time and then again after the break. *BH* said that when a Council member tells a presenter that their time is up, the presenter should sit down immediately. *Mark Dunlop* felt that the use of acronyms was still too high. Overall, the group felt that the meetings were improving. *SS* stated that the Council members who will be working with the next presenters should stay focused on what the Council wants to know. She said that presenters should be aiming their discussions toward the accessibility to service on the part of consumers new to San Francisco. *Cecelia Chung* advised that the Council should put a clear definition behind transgender because there is confusion in collecting data in regards to male to female versus female to male.

Consumer Input Forum
BH talked about the 44-member focus group that met on 6/26/01. Despite the initial confusion, the Caucus collected good data pertaining to the services they receive. Key points of the Focus Group were compiled. A Spanish speaking focus group was being held on 06/28/01. Also, the surveys that have been distributed have been collected and number about 300. *Gary Harrell* has volunteered to create a database and input the data. However, *BH* suggested that the Caucus couldn't possibly have their presentation done by July 9th. The idea of hiring data entry temp would expedite the process of finishing the report for the PWA Caucus in a timely manner. Brad said that there would be a Caucus meeting on July 11 to disseminate the information. *LT* distributed a draft of the Prioritization Process and Timeline.

Preparation for next Council Meeting
Adjustments to the presentation schedule were discussed.

Adjournment

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Minutes, July 9, 2001 HIV HEALTH SERVICES PLANNING COUNCIL
Draft until approved by Council at next meeting

I. Call to Order
4:40 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda was reviewed. A change was made in order to add five minutes to the presentation about housing services. The agenda was then approved.

IV. Review and Approval of Minutes
6/11/01 Council Meeting Minutes – two changes were requested in order to correct the information about services in Marin County. It was then moved to adopt the Minutes as corrected. By voice vote, the Council Meeting Minutes were approved. Two members abstained.

V. General Announcements
Catherine Geanuracos reminded the Council about a joint meeting with the HIV Prevention Planning Council on July 30th at 5:00 PM, Room 201 in City Hall. *Brad Hume* announced an extra meeting of the PWA Caucus scheduled for Wednesday July 11th from 5:30-7:00 PM, Room 330 at 25 Van Ness.

VI. Public Comment
Marcy Fraser from Continuum spoke on behalf of the HIV and AIDS Provider Network. She said that the Provider Network desired to give monthly updates during this part of the Council agenda. She extended appreciation to the Council for how service category presentations had been handled during the Prioritization process. She added a comment about the benefit of a provider presenter having the chance to partner with a Council representative. HAPN wants to continue to have a partnership with the Council and with the Health Commission, when planning issues are taken up at all levels of the service system. On a separate topic, she mentioned that as of that date very few contracts had been certified for the current fiscal year. Some agencies are being forced to borrow money and/or undergo difficult budget processes in order to cover outlays of funds. She also spoke about evaluations concerning cultural competency. Meetings of the Provider Network take place on the first Friday of each month, at 9 AM.

VII. Reports

VIII. Membership Committee
Janis Takamoto reported that the Committee wanted to recommend the re-appointment of two members, Mark Dunlop and Jim Mitulski. An information sheet was passed around. The Committee's recommendation was approved by unanimous voice vote. At this point, it was mentioned that new members and re-appointed members had not yet received official letters from the Mayor's office, which leaves everyone still unsure about the dates of appointment.

IX. Housing Services presentation
Susan Shea talked briefly about the overall Prioritization process and introduced *Brad Hume* who has been the Council member working with *Margot Antonetty,* a Program Manager from DPH-Housing and Urban Health, to prepare for this presentation. *BH* announced that there would be 10 minutes for questions at the end of the presentation. Margot first introduced the Director and other program managers working at DPH-HUH. *MA* delivered the 2002-2003 Prioritization Housing report. She began with an overview about how DPH-HIV Health Services is the federal grantee for CARE Title I funds. However, funds that have been allocated by the Planning Council to the Housing category are

administered by a different section of the Health Department known as Housing and Urban Health. Housing and Urban Health is a section within the Health Department responsible for implementing and maintaining a wide range of housing options for homeless, disabled, and low-income people. In addition to the CARE funding, housing activities are funded by grants from the U.S. Dept. of Housing and Urban Development (HUD). This funding source provides a significant amount of support designated for HIV/AIDS housing through the Housing Opportunities for People with AIDS (HOPWA) program. This program is administered through the San Francisco Redevelopment Agency. HOPWA funds can be used for the capital development of housing projects, while CARE funds may not. For fiscal year 01-02, HOPWA funding is being allocated in the following manner: Capital Projects: $456,916; Support Services and Operating: $3,792,100; and Rental Assistance: $3,638,151. As a reminder, *MA* said that it was important to remember that there are many other housing programs in operation or under development that can and do provide housing for persons with HIV/AIDS. Housing services make up approximately $6.9 million or 16.6% of the total CARE budget. This money is utilized in three sub-categories: emergency housing, transitional housing and residential programs/subsidies. Emergency housing funds are utilized primarily for hotel vouchers of very short duration intended to assist clients with immediate housing crisis. Transitional housing funds are utilized in short-term residential programs intended to stabilize an individual and to support transition to a longer-term sustainable housing situation. These programs include substance abuse and mental health services. Residential programs and rental assistance/subsidies are designed for longer-term stabilization. These services are often linked to case management and other services, all intended to further support a client's health.

The intention of housing as part of the service system is to improve the health of people with HIV and AIDS. She stated that there are approximately 16,000 homeless people in San Francisco and that 7 to 12% of that group are HIV+ (between 1,100 and 1,900 people). Housing is the largest unmet need as identified by both consumers and medical providers. Lack of housing is one of the most significant barriers to care in San Francisco. The HIV Health Services Client survey found that 63% of persons that were homeless at the time of the study were not taking HIV-related medicines. Instability of housing reduces adherence to HIV medication regimens. Maintaining the stability of the client, especially the HIV+ client, is the overall objective for housing services because this allows for regularity in medications and other primary care.

She reviewed the Housing Wait List demographics according to ethnicity, income, gender, and age. The sub-categories of Emergency Housing, Transitional Housing, Residential/ Subsidies, and Combined Housing Services (n=2,113 people) were also broken down by ethnicity, age, and gender. *MA* stated that 99.1% of the money that the Planning Council allocated in FY 00-01 had been spent (only residential subsidies had a slight amount of under-spending). Targets for Units of Service and Unduplicated Clients were fully achieved, even exceeded. Finally, she read the recommendations that were a collaborative effort between CARE funded housing providers, the Planning Council's Housing Committee and DPH–Housing and Urban Health: 1) Maintain and improve current housing stock; 2) Promote housing stabilization; 3) Broaden available housing opportunities. Her bottom-line message: HOUSING IS HEALTHCARE!

Amy Cunninghis from the San Francisco AIDS Foundation reviewed the questions that the Council prepared for providers. She was speaking on behalf of the providers in the housing category. The most urgent unmet need in the Housing category is affordable, long-term housing with supportive services, particularly for dually diagnosed clients. Many people spend year after year in emergency housing, shelters, and SROs while they languish on housing wait lists. Mental health and substance abuse issues may keep these clients from maintaining a stable housing situation, in a group living situation particularly. Amy pointed out that there are a few successful housing programs in the City that meet the needs of dually and triply diagnosed clients (maintaining shelter and a connection to primary care), but these are not sufficient. She reviewed the hypothetical case of an HIV+, substance user who also

suffers from mental health problems. This person does access other CARE-funded services such as transportation, several case management agencies to obtain vouchers, and some primary care services. However, due to his lack of stable housing, his problems are exacerbated and his physical and mental health is unstable. For many years his housing has consisted of sleeping in the streets, staying in emergency shelters, using vouchers, and staying with friends. In one instance, he was referred to a housing provider by the Wait List, but the provider couldn't locate him. Another time he missed four intake appointments and lost his chance at a slot. This is an example of the type of client who would benefit from a longer-term situation with on-site supportive services. Housing services can bring people not in care into care. Once the client, such as the one in the example, establishes stable housing, regular primary care and other services that benefit the client's well being may be stabilized as well. Housing providers try to ensure linkage to primary care for all their clients. Case Managers assist the clients in making and keeping scheduled appointments and otherwise address the needs of the client. She said that just providing shelter isn't enough. Support services attempt to maintain an ongoing connection to primary care. In the various housing programs, clients have varying degrees of independent living and varying degrees of supportive services, depending on client needs.

Who are they not reaching? In San Francisco, housing providers have to recognize that there are thousands of people they are not reaching. There are simply not enough resources, either the funding or the affordable housing, to meet the needs. The needs run the gamut from the person who wants to get off the streets into a stable environment with a range of support services to the person with his own apartment and gets behind on the rent for some reason. Then there is the clients who finds a place that is somewhat affordable but has no means of coming up with first/last & security in order to move in or the client who is in a situation where the rent increases annually more than his Social Security income. Market conditions are driving people out of their current housing. There are few protections. Many types of need are presented by people with HIV/AIDS in this marketplace.

When one dollar is taken from one area and applied to another area it creates the need for more housing services due to greater instability. It invariably costs more money to supplement what has been reduced and an apartment in today's market invariably costs more money than in yesterday's market. She added that flat funding this year does not provide the same level of services as last year. She reiterated that keeping people in their housing is of the utmost importance. Increasing the number of affordable housing opportunities is imperative, as well as providing emergency housing, vouchers, and SROs. *Mary Jane Wood* asked the tough question about a "flat funding environment" at best and how providers would propose reducing services in order to increase the number of affordable housing units. Amy answered with a challenge to the Council on that point. Providers are asked to survey the overall situation and make recommendations about needs within the service system as a whole. *MJW* pressed Amy and other providers to help identify services that could be reduced. Amy said she was incapable of examining other service categories, being very busy with housing issues. *MJW* limited the question to within housing services. Amy expressed her personal view that while no cuts were preferable, she felt that long-term stable housing was the key to maintaining people in care. That meant this area would take priority over emergency and shorter-term services—leaving a gap in services. All facets of the housing system are important and each has its way of linking to treatment for clients. *Rob Whitford* asked about the emergency vouchers and how they are used to access rooms in SROs. Amy spoke briefly about the changes away from a voucher-based system for emergency housing to a redesigned setup with a block of master-leased rooms in a single hotel or perhaps two hotels. *MA* added further information on this changeover, which will have the added benefit of giving DPH greater leverage to improve conditions in the SROs that have these leases. *Wayne Peace* asked if two different subsidy programs could be combined into one. The answer was no. *Larry Cruz* asked about Section 8 and its relationship to residential programs. Is greater coordination between these programs possible? *MA* responded that this is a separate housing option for people with HIV/AIDS. During open enrollment, a household may get on the Section 8 wait list and may rise rapidly to the top. The SF Redevelopment Agency has a good working relationship with the Housing Authority, which administers Section 8, and

with AIDS service organizations seeking to place clients.

X. Client Advocacy/Benefits Counseling and Financial Services

Council member *Mark Dunlop* introduced this service category and Program Manager Hilda Jones. Hilda pointed out that the service of Emergency Financial Assistance was listed under the Housing category for budgetary purposes but was grouped here with benefits counseling and money management. Numerous handouts were distributed. Next, she reviewed the demographic data on clients in benefits counseling, in money management and in emergency financial assistance. She found that benefits counseling served primarily white gay males over the age of 26, with African-American males and heterosexual women the next categories but much lower in numbers. Money management, however, showed a more equitable distribution of ethnicity served, as did emergency financial assistance. She questioned whether services associated with benefits counseling were reaching the target populations identified by the Council as those with most severe need. She urged the Council to consider this during their prioritization. She viewed the services in this category as being critical for the other target population of people "not in care." Providers under this category have a very limited amount of funding and rely heavily on public funding to operate. She suggested that providers in this category need some technical assistance in doing private fundraising. Next, Hilda introduced the service provider contributing to the presentation.

Kevin Fauteux, Director of Lutheran Social Services Money Management Program, was also representing AIDS Emergency Fund and Positive Resource Center. He started by giving the brief history of a few clients in order to illustrate the answers to the Council's five questions. He outlined a scenario whereby "Mary" has recently been released from a local hospital after being diagnosed with disabling HIV. She is placed in a SRO for one week with a voucher. At the end of the week, she left the hotel and was able to re-qualify for SSI. This process was totally overwhelming to her and so she sought General Assistance funds and was sent back on the street with $187. Mary cannot afford a place to stay and ends up blowing her money. From the streets she is soon back in the emergency room for another hospitalization. *KF* stated that this is among many examples of unmet need in San Francisco. Clients cannot afford even the worst of the SROs that have rents at about $250 per week for a disgusting room with no bathroom. People like Mary cannot get through the maize of Social Security. They fall through the cracks and end up trapped repeating the cycle of homelessness, emergency room visits, SRO rooms, and back to homelessness. It is a vicious cycle.

Kevin next highlighted another case: "Joe," a former substance user has just been released from incarceration. He has been given his $200 gate money to use for a week in a hotel. After that he has no place to go, no resources, no job, no benefits and he has AIDS. Kevin talked about how Joe was able to utilize services from AEF and PRC in order get emergency help and get through the minefields of Social Security with doctor's verifications and primary care. Thus, he was able to get SSI. Also, he was provided with money management that translates his SSI deposit into his rent, his utilities, his appliances, and his phone. These are all key to his stability. AIDS agencies working together can provide real benefits to people like Joe so that they can attain housing stabilization. Once this is achieved, primary care can be started and maintained. Housing makes all the difference in survival. AIDS service organizations that provide client advocacy can translate their advocacy service into the pieces of a financial foundation.

It is homeless individuals who are not being served. Kevin recommended new techniques for outreach to these "not-in-care" populations, such as outreach worker-nurse communication and greater outreach to the prisons and hospitals. The providers in the category of Client Advocacy/Financial Services are starting to have wait list, something that is very destructive in the hypothetical cases just reviewed.

XI. Client Advocacy/Legal Services

Mark Dunlop next introduced Program Manager Joseph Cecere from HIV Health Services. Joseph first

passed around some materials and defined legal services as any direct service utilizing the skills of an attorney, such as immigration, wills, power of attorney, housing and eviction. Joseph directed the Council's attention to a pie chart showing that CARE Title I only constitutes 22% of the total funding for HIV Health Services in 2000 and Legal Services represent only 1% out of the Title I funding pie. Additionally, he compared the ethnic breakdown for people living with AIDS and those that receive legal assistance. He said that Latino/as receive a higher degree of legal assistance than other ethnic groups because of the need to utilize immigration attorneys. Joseph stated that women comprise a disproportionately higher representation of the clients utilizing this service. Units of Service were on target and were achieved. Unduplicated client counts were slightly under the projections. He then turned the presentation over to the three providers for short presentations.

Bill Hirsh, Director of the AIDS Legal Referral Panel, provided a brief history of the ALRP that has been in existence since 1983. He stated that his agency leverages close to $1 million in donated legal services for this community each year. They offer a wide range of services for PLWH, such as wills, credit problems, eviction, job discrimination. After the initial intake, they are able to provide some in-house services or refer clients to panel attorneys. The existence of the program depends on the work of volunteer panel attorneys. He said that in the early years of the epidemic, the bulk of the caseload surrounded the creation of wills or durable power of attorney. With longer life expectancy, the legal issues have changed considerably. Currently, the financial problems of people living with HIV comprise most of their caseload (they are limited by the areas of expertise embodied in the corps of panel attorneys; limitations are most notable in bankruptcy, insurance matters and tax issues). The housing-related caseload has doubled over the past few years, and now constitutes one quarter of all cases. That has necessitated a change in service delivery from referral to panel attorneys to staff attorneys taking on direct representation in the area with housing, with a focus on eviction prevention. Work is also done in training other AIDS organizations to recognize particular legal issues. Training is also provided to the panel attorneys.

Janet Feldon, supervising attorney for the HIV Immigration Project, which is a project of the Volunteer Legal Services, spoke next. She has worked on this project since 1992. The primary concern faced by her organization is how to keep clients in the US legally in order to continue with medical treatment for HIV. To return to their home countries can often mean death for many immigrants because of lack of care. She said that laws may change from year to year, sometimes in favor of her clients, sometimes not. *JF* cited the example of the first HIV+ gay man who was granted political asylum in 1995 because of his sexual orientation and HIV status. She cited another example of a man working on HIV/AIDS issues in his home country before being kidnapped along with his partner, who he never saw after that incident. This client arrived here in 1999, and received an attorney from this project. In April 2000, he won his case for political asylum. One year later he became eligible to a legal resident and to receive most types of assistance. Other clients have endured police brutality in their home countries. However, a person must now file an application for political asylum within one year of entering the USA. She said that a time limit was never imposed before and this has had a negative effect on her clients. This is because some are so traumatized that it takes them many years to tell their stories of terror and abuse. Now they have 12 months to pull it together.

Shannon Wilbur, Director at Legal services for Children, a non-profit law office that provides legal services and related social services to children and youth. They retain both attorneys and social workers on their staff enabling them to offer a wide range of representation to their clients. The CARE dollars that they receive support their HOPE Project, which serves legal and social services to families with children affected by HIV/AIDS. The purpose of the project is to help the families stabilize and plan for the future care of their children. Adoption, emancipation, guardianship, and powers of attorney are some of the areas that are discussed after family assessment takes place. The Family Activity Program provides respite care, field trips, community building, and informal support among the families themselves. She talked about a client, a single mom, who is HIV+ with three HIV-negative

children of various ages coming to the program for support. The primary caregiver for the children is the maternal grandmother. The attorneys and social workers work with this client to develop the best plan of action for her children to promote stability. It is decided that joint guardianship between the mom and her mother is the best course. The Hope Project stays very involved with the children and the family for three years after making the legal arrangements. She talked about the continuing need for legal assistance, crisis intervention and basic social services due to a variety of issues facing the children.

XII. Break

XIII. Transportation

Mark Dunlop introduced Hilda Jones, DPH-HHS Program Manager, to begin this service category presentation. The funding in this category is primarily for van transportation provided to clients in order to maintain medical appointments, social services appointments, do shopping at the grocery center connected with Project Open Hand, and some very limited moving services. Other transportation services, such as Muni tokens and taxi vouchers, are funded at times when money is available through rollover funds, but are not part of the regular CARE budget. This service category receives a small amount of General Fund support in addition to the CARE funding. The Units of Services are based on one hour of transportation services. This includes the scheduling, pick-up, delivery, and drop-off of clients. The provider, Shanti Project, is working at capacity on a five-day-per-week basis, with some of the van fleet getting old and in need of maintenance. They may not be able to handle additional clients if increased transportation service was to be provided for more new clients currently "not in care." She introduced Hosea Turner from the Shanti Project.

Hosea Turner, Manager of Shanti Transportation Programs, said that Shanti Project is the only agency in San Francisco that provides free transportation to people with disabilities, particularly from HIV and AIDS. He described the features of the vans currently in use, such as lifts. The service is crucial to the daily existence of the people that it serves. He said that more transportation is needed because there are still many people who cannot make medical appointments or get groceries. Hosea described transportation as the vital link to primary care. Healthcare providers and social workers can plan treatment for clients, but if the client cannot physically access treatment then primary care is not really happening. Who are they not reaching? The poor, low income people, non-English speaking people, people using substances, and people fearful of neighbors seeing the van picking them up comprise part of the population not being reached. He said that stabilizing housing and food has an effect on transportation because a more stable client base makes it easier to locate people requiring transportation. He suggested that Council members come to Shanti and speak with the van drivers or perhaps ride with them and speak to the clients. There is no waiting list. Clients just need to call Shanti in order to receive the service.

XIV. Day and Respite Care

MD again introduced Joseph Cecere from the AIDS Office. Joseph referred everyone to the handout. He said there are two service providers in this category; he described the differences between Adult Day Healthcare and Respite/Childcare. Adult Day Healthcare Programs are licensed by the State and offer a full range of services to clients including: nursing care, social services, physical and occupational therapies, art therapy, recreation and peer support, and in San Francisco, substance abuse services and transportation to and from the facilities. They also serve meals. Respite/Childcare is provided to families that are affected by HIV/AIDS. The program provides a break or respite to the primary care giver in the home. This is accomplished by sending another person into the home to provide care for the child or children. At least one person in the home must be HIV+ to be eligible for this service. It is not standard childcare. He next surveyed the ethnicity demographics for the Adult Day/Respite care portion of this service category, finding that this service was being utilized by a slightly larger percentage of African-Americans and under-utilized by Latino/as when compared to the

numbers in the overall living AIDS cases. Gender demographics revealed heavy utilization by female clients when compared with the numbers of living AIDS cases. With Respite/Childcare, higher percentages of African Americans and Latino/as, as well as females, are utilizing this service than their numbers in the overall living AIDS cases. The handout also contained information about Units of Service and Unduplicated Clients. He then invited the providers to speak.

Marcy Fraser spoke about the Adult Day Health Program, one of the six programs operated by Continuum. It is Continuum's most expensive program because it is so service-intensive and is the only Adult Day Health program for people with AIDS remaining in the U.S. She said that this service is supported by CARE funding, private donations, and Medi-Cal billing. Private donations increase the services by about $200,000 per year and allow the program to provide additional nursing staff, rehabilitation, increased transportation, substance abuse programs, and food programs. It is a structured program, not a drop-in clinic. The clients are enrolled in the program and must stay and participate for a certain number of hours per day to remain eligible for services. Medi-Cal reimbursement pays only about two-thirds of the actual cost to Continuum per client. She said that the success of their program might be measured in the numbers of former clients who now hold jobs at Continuum and Shanti. Marcy said they feel considerably better about that than the pattern of prior usage when many clients died. She said the program has been able to create a very supportive atmosphere for women clients. She closed by saying that Continuum really relied on the CARE funding allocated by the Planning Council.

Stephanie Morgan, Program Supervisor from Family Support Services of the Bay Area, spoke next. They provide 24-hour respite care to children aged 2 weeks to 12 years old. They provide in-home and out-of-home care. In-home care is provided by family aides who are full-time staff. Out-of-home care is provided by licensed day care homes, located throughout the City. Site-based care takes place at various agencies that provide support groups. They take referrals from Case Managers who are in a position to identify the needs. There is another main office located in Oakland and their service operates Bay Area-wide. She reviewed the intake process for the families and the review process utilized prior to providing services within the home of a client. She also reviewed the type of medical care they can provide (non-invasive). She said that the responsibilities of the providers were to engage children in age-appropriate activities, such as outings. The program also helps families assist the children in adjusting to their medications.

Susan Shea explained that this ended the presentations about service categories. The next order of business is consumer input. Two formats have been employed for consumer input. The focus group format would be presented in this meeting. The focus group was arranged by the REACH cohort to obtain information about people not in care, in an effort to understand their needs. Next meeting the Council will be hearing consumer input gathered by members of the PWA Caucus.

XV. Consumer Input/Needs Assessment Data from Focus Group

Laura Thomas distributed some materials that would be needed by Council members during the upcoming meetings. She asked that members read the materials between meetings. Then she presented information collected from a 06/19/01 Health Utilization Focus Group. This focus group was conducted for the purpose of learning more about barriers to medical care experienced by individuals living with HIV in San Francisco. She stated that the focus group participants were recruited from the UCSF REACH Project, a longitudinal study that has been researching access to medical care and HIV medications in the homeless and marginally housed population since 1995. Of the 12 individuals recruited, ten participated and two were no-shows. Each participant was paid $15 for his or her participation. The focus group began with each participant describing their experiences getting medical care when they were first diagnosed with HIV. Typically, participants in the group sought medical care soon after testing positive and found few barriers to finding a doctor. Some were referred to medical care while incarcerated or while receiving substance abuse treatment. When asked where they would

like to see more funding, the group strongly indicated housing. They wanted their opinions about housing expressed to the Mayor and wanted to know why he did not have more involvement. According to the group, lack of housing was one of the major barriers to receiving care. Things that made it easier to access care were good doctors, care in their homes, ability to have drop-in appointments, and ADAP to help pay for medications. When asked directly about barriers to medical care that they had experienced, the group raised the issue of access to insurance. In general, access to Medi-Cal or other insurance was felt to improve one's access to medical care. Drug addiction was also an issue that interfered with accessing medical care, with participants describing bad attitudes toward drug users and missed appointments. Laura said that the quality of care at the VA was an area of concern to some participants who qualified for veteran's services. A lack of burial benefits and life insurance were two areas of potential need addressed by the focus group, too. They expressed concern that they wanted to keep their families provided for upon their demise. In general, the things that made it difficult for them to access care were homelessness, drug use and mental illness ranging from depression to denial and embarrassment about HIV. Laura offered a handout that highlighted the dialogue that occurred within the focus group. In response to a question, Laura said that there was a sense of knowing where to access medical care and how to do so. She closed by saying that staff working with the REACH Project were very interested in continuing collaboration with the Planning Council. They feel the cohort of people that they have been following can help inform the Council about needs.

XVI. Report-back from Phoenix meeting sponsored by HRSA

Catherine Geanuracos and *Stephan Oxendine* provided a summary of the highlights from the HRSA meeting. *CG* said they would attempt to reduce two days into five minutes. One of the main points driven home by HRSA representatives was the need to assess the needs of people not in care and to structure services to enroll people not currently receiving primary medical care into care. She stated that this theme was repeatedly referred to throughout the meeting by HRSA. Another theme was in eliminating barriers to access and service facilitation. Still another topic of discussion was quality management and outcome evaluation. Yet another had to do with increased coordination with substance abuse treatment. *CG* said that HRSA wants to know the number of people in our EMA that are not in care and what plan the Council has to get them into care. This will affect the Council by shifting the focus of our year-long needs assessment away from CARE funded clients toward a population-based needs assessment of people with HIV who may or may not be receiving care. Clearly, HRSA is more interested in the people that are not in care. HRSA suggests determining quality management accountability through assessment of whether or not care is provided in accordance with Public Health Service guidelines for treatment of HIV disease. *Stephan Oxendine* reiterated Catherine's main point that HRSA is looking for ways to get people not in care into care. He amplified what had just been said about collaboration and coordination. He mentioned a session in the HRSA meeting about Planning Council responsibilities given the new language of the Reauthorized Act. Obviously, this Council has already taken a look at its Bylaws and made recommended changes. He felt that members understood what was involved in Planning Council responsibilities. The CBC Initiative was the subject of another session during the meeting in Phoenix in order to clarify the proper use of those dollars. Another issue centered on changing the case reporting system from AIDS cases to HIV prevalence. This change must be completed by 2005. Capacity building was also discussed, with many participants feeling that primary care would suffer as a result of having to devote money to building capacity among minority-based agencies. CBC funds are not to be used to supplant other funds going to already-existing programs. He also took away from the HRSA meeting a greater appreciation for the good relationship with the Grantee, which prevails in our EMA and is not the case in other EMAs. Horror stories were told, and some Grantees may be operating outside the bounds of the legislative requirements. In some cases, HRSA was actually asked to intervene in these disputes. *SS* asked a question about how HRSA envisions the increased levels of service implied by bringing new people into care, while at the same time having to downsize and decrease the service system by virtue of reduced funding. The response was that HRSA may understand the pain involved, but still wants that

dilemma to be overcome by assessing the needs of people not in care and developing a plan to get them into care. There was a lot of understanding and empathy. Nonetheless, just do it. Perhaps the efforts to coordinate the Council's work with that of the Prevention Council can lead to fruitful collaboration in the use of outreach workers to get people not in care. *MJW* asked about the mandate having to do with quality assurance standards. HRSA seems to be still in the process of defining what their expectations are with regard to Quality Management. At this point they were able to point to a few examples of EMAs taking up this process. Although our Reggie data is not perfect, we do have a data collection scheme that other EMAs are just starting from scratch. We have at least the beginnings of a mechanism to track client-level clinical markers, not to mention the research this Council undertakes with regard to quality assurance and standards of care. We will simply need coordination in this effort and perhaps an upgrade in effort, according to Catherine and Steve. *Jeff Byers* clarified what he believed was the HRSA focus: people who know their status (HIV+) but are not in care. He said that prevention efforts usually focus on outreach to people who don't know their status because they have not tested recently. That argues for a plan that goes beyond attempting to coordinate with HIV prevention councils and the prevention-oriented outreach. Laura Thomas added that HRSA utilizes a national framework for viewing the epidemic, a framework that doesn't always fit with the nature of our local situation. For example, nationally perhaps one-third of people infected with HIV know their status but are not in care. She expressed the view that such a percentage would not apply to San Francisco. She estimated that perhaps 20% here fit the definition of "not in care." That is still a significant challenge. She said that generally speaking, HRSA is in a bit of a bind at present and is passing along to our level some of their indecision and is prone to issuing tardy recommendations.

XVII. Unfunds Process Report

Susan Shea said that she was discussing Unfunds tonight because these funds would play a huge role in the planning process that would be taking place during the next few Council meetings. How the Council prioritizes the use of Unfunds will have to merge with how the Council formulates the goals and objectives that we want the AIDS Office to accomplish next year. The reason it will play a large role is because in actuality and reality the CARE Council has very few pots of money to manipulate without completely disrupting the system as it stands now. One of these pots is the rollover dollars from last year and the other one is the Congressional Black Caucus pot that will likely be receiving increased funds next year. If the Council decides that something is particularly important to do in the next year, the Council will need to decide which program the money will be taken from in order to accomplish that important objective. *Susan* suggested that the Unfunds could be utilized to augment an existing program or to look at quality management or a Needs Assessment. *SS* said that the Unfunds policy and procedure that was adopted by the Council last year came out of the Implementation and Evaluation Committee. It was an attempt to put some kind of methodology to the two cycles of money that come to the Council every year as rollover dollars. The policy and procedure adopted last year was developed through consultation with the AIDS Office, consumers, contractors, and Planning Council members.

Her focus was on the rollover funds that become available at the end of the fiscal year, and they are the ones that are left on the table by the contractors who were not able to use every dollar in their contracts. This money must be sent back to the AIDS Office. *SS* said that the dollar amount is then taken to HRSA and must be applied to projects, put into those contracts and expended by the contractors before March 1st. She said that they are good solely for one-time-only projects. The dollar amounts are unpredictable due to contractor's needs during the year. She referred to a report from HIV Health Services in order to arrive at a figure of $886,000 in rollover money now available. *SS* stated that the Council would have to decide what kinds of projects would be appropriate to receive these funds. She said that the Council would have to determine if an objective, which is listed as a priority, would require funding. The Council will have to determine where the necessary funds will come from (new money or rollover money, for example). *SS* reviewed the three categories that the Council developed last year that are appropriate for receiving Unfunds. The Council received a larger award from HRSA

this year and therefore did not have to use Unfunds to cover deficits as it had in the past. She said that while household goods, food, and transportation vouchers were not specified under a specific category, the Council was still responsible for reserving some money from the rollover to sustain those services. Additionally, dollars should be used to develop assessments or methodologies to reach the not-in-care population and bring specific numbers of them into care.

XVIII. Facilitator and Group Process

Susan Shea spoke briefly about the facilitator hired to work with the Council at the next three Prioritization meetings. She said it was everyone's hope that the facilitator would help choreograph the next three Council meetings. She expressed the belief that Council members understand what must be accomplished in terms of goals and objectives. A draft document will be prepared beforehand. This will help create a list that people can easily add to and/or subtract from. In the Prioritization process the Council is required to formulate its list of service categories arranged from the most important to the lowest relative importance. Then the Council needs to formulate a slate of goals and objectives. Finally, the Council needs to allocate the funding, a discussion that will include the Congressional Black Caucus money and the Unfunds. These allocations will probably be based on the premise of receiving an amount this year roughly equal to last year's award. She concluded by thanking the Council members that have worked with the Prioritization Organizing Committee over the past three or four months.

XIX. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

July 9, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P									
2. Toni Butler	*TB*										
3. Jeff Byers	*JB*	P									
4. Bart Casimir	*BC*										
5. Cecilia Chung	*CC*	P									
6. Raymond Combs	*RC*										
7. John Conley	*JC*	P									
8. Larry Cruz	*LC*	P									
9. Mark Dunlop	*MD*	P									
10. Gregory Edwards	*GE*										
11. Donald Frazier	*DF*	P									
12. Catherine Geanuracos	*CG*	P									
13. Fernando Gomez-Benitez	*FGB*	E									
14. Gene Gowdey	*GG*										
15. Gary Harrell	*GH*										
16. Brad Hume	*BH*	P									
17. Anthony Huynh	*AH*	P									
18. Sam Kaplan	*SK*	P									
19. Gene London	*GL*	P									
20. Carmen Madríz	*CM*										
21. Allen Meyer	*AM*										
22. Jim Mitulski	*JM*										
23. Gregory Neumark	*GN*										
24. Stephan Oxendine	*SO*	P									
25. Edward Patterson	*EP*	P									
26. Wayne Peace	*WP*	P									
27. Ken Pearce	*KP*	P									
28. Alissa Riker	*AR*	P									
29. M.Jay Sanders	*MJS*	P									
30. Susan Shea	*SS*	P									
31. Janis Takamoto	*JT*	P									
32. Bob Teague	*BT*										
33. Jose Villarce	*JV*	P									
34. Robert Whitford	*RW*	P									
35. Mary Jane Wood	*MJW*	P									
36. Karen Wuopio	*KW*	P									

HIV Health Services Planning Council

City Hall, Room 201 1 Dr. Carlton B. Goodlett Place

July 23, 2001 4:30 PM

AGENDA

Revised

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I.	**Call to order**	4:30 PM
II.	**Roll Call**	4:32 PM
III.	**Review and Approval of Agenda**	4:34 PM
IV.	**Review and Approval of Minutes,** 6/25 — **VOTE**	4:36 PM
V.	**General Announcements**	4:38 PM
VI.	**Public Comment**	4:41 PM
VII.	**Reports**	
	• *PWA Caucus Presentation on Consumer Needs*	4:46 PM
	• *Review of Priority Setting – Materials, Definitions, Budget, HRSA, etc.*	5:11 PM
	- Laura Thomas	
	• *HIV Health Services*	5:41 PM
	- Michelle Long Dixon and Russ Zellers	
	• *Intro to Group Decision-Making Process (guidelines and expectations)*	5:55 PM
	- Monika Hudson, Facilitator	
VIII.	**Break**	6:25 PM
	• *Discussion: Priority Order of Service Categories* — **VOTE**	6:35 PM
	• *Discussion: Draft Goals and Objectives* — **VOTE**	6:55 PM
	- For the Service Categories of Housing and Health Care	
IX.	**New Business**	7:29 PM
X.	**Adjourn**	7:30 PM

Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Mon	7/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	7/30	HIV Health Services Planning Council (Joint Mtg. w/ Prevention Plan Council)	City Hall, Room 201	5:00 – 7:30 PM
Wed	8/1	Housing Committee	25 Van Ness, 7th fl, Room 701	3:00 – 5:00 PM
Wed	8/1	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	8/2	Prioritization Organizing Comm.	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	8/13	HIV Health Services Planning Council	25 Van Ness, Room 330-A ?	4:30 – 7:30 PM
Thurs	8/16	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	8/27	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

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HIV Health Services Planning Council

City Hall, Room 201 1 Dr. Carlton B. Goodlett Place

see revised agenda

July 23, 2001 4:30 PM

AGENDA

07-20-01P12:01 RCVD

DOCUMENTS DEPT.

JUL 20 2001

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I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 6/25 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:38 PM**
VI.	**Public Comment**	**4:41 PM**
VII.	**Reports**	
	• *PWA Caucus Presentation on Consumer Needs*	**4:46 PM**
	• *Review of Priority Setting – Materials, Definitions, Budget, HRSA, etc.*	**5:01 PM**
	- Laura Thomas	
	• *HIV Health Services*	**5:31 PM**
	- Michelle Long Dixon and Russ Zellers	
	• *Intro to Group Decision-Making Process (guidelines and expectations)*	**5:45 PM**
	- Monika Hudson, Facilitator	
VIII.	**Break**	**6:15 PM**
	• *Discussion: Priority Order of Service Categories* — **VOTE**	**6:25 PM**
	• *Discussion: Draft Goals and Objectives* — **VOTE**	**6:45 PM**
	- For the Service Categories of Housing and Health Care	
	• *Discussion: Evaluation of this Meeting*	**7:20 PM**
IX.	**New Business**	**7:29 PM**
X.	**Adjourn**	**7:30 PM**

Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Mon	7/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	7/30	HIV Health Services Planning Council (Joint Mtg. w/ Prevention Plan Council)	City Hall, Room 201	5:00 – 7:30 PM
Wed	8/1	Housing Committee	25 Van Ness, 7th fl, Room 701	3:00 – 5:00 PM
Wed	8/1	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	8/2	Prioritization Organizing Comm.	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	8/13	HIV Health Services Planning Council	25 Van Ness, Room 330-A ?	4:30 – 7:30 PM
Thurs	8/16	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
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2001-02 ***OBJECTIVES***	***HIV HEALTH SVS Response:2001-02***
3. Maximize use of **other funding streams for dental care**, especially Medi-Cal and TITLE F reimbursement. 11. Further decentralize dental services: expand available services and co-locate at additional sites.	2001 RFP for decentralized dental services requires Denti-Cal billing; contractors assessed during monitoring as to whether Denti-Cal is billed; deficiencies noted and follow-up is in process
4.Maximize use of **Medi-Cal for home health care** (including use of the Medi-Cal waiver program)	Progress made over the last year but some clients and staff still not familiar with Medi-Cal Waiver Program. MOU currently in place between residential sites and Medi-Cal Waiver contractors to increase participation in Waiver Program. No limit to the number of clients that may be served through the Waiver program; the state allows for program growth through the addition of staff as caseloads increase (30-45 pts = 1.0 FTE RN and 1.0 FTE MSW); at least one contractor has already added staff. Additional information sharing about program eligibility (Karnofsky < 60), may be necessary to increase referrals from physicians, case managers, etc. As of 3/9/01 both Waiver Program contractors had short waiting lists (under 10 each) which were mostly due to staff turnover and hiring delays (nursing shortage). Both had done some outreach and information sharing with providers in the past, and will do more outreach as needed. The CARE contractor's mailing list was shared with both contractors for the purpose of additional outreach and correspondence with CARE providers.
5. Analyze the utilization of and need for attendant care as compared to the need for practical support services	Consultant hired, advisory group formed; group addressing practical support issue along with Case Management, Peer and Treatment Advocacy issues. Case Management/Peer Advocacy/Treatment Advocacy assessment and standards of care group to consider coordination between Peer Advocacy and Attendant Care services.Subcommittee has met to address identified issues; work group to continue meeting
6. Pharmaceutical staffing services need to be augmented with General Fund dollars in order to improve the quality of service for CARE clients	No genreal funds allocated and pharmacy services has now been out sourced to community pharmacies.
7. Direct to AIDS Office to assess the availability of **emerging diagnostic testing**, such as genotypic and phenotypic testing.	FULLY ACHIEVED (within the limitations of current funding) State Office of AIDS secured $2.4 million for FY 2000-01 to cover the cost of approx. 6,000 tests (statewide) for low income clients without third party coverage (Medi-Cal also covers testing); program known as "HIV Diagnostic Assay Program"; includes Viral Load testing for same population. All primary care sites may participate; local site of resistance testing is on SFGH campus at Gladstone (R. Grant, MD). The viral load testing facility is SFDPH Public Health Lab (Sally Liska, Dr.PH); dissemination of information was completed via announcement to all primary care and case management programs; testing is underway.An under-utilization of resistance testing was reported by State; probably due to an over-projection of need; funds for Viral Load testing are being used quickly in SF. SFDPH request made to State to reallocate unspent dollars from other State funded programs into viral load testing as needed; State has taken this request under advisement. Amount of additional Title I dollars awarded are insufficient to fully fund viral load and resistance testing.

2001-02 *OBJECTIVES*	***HIV HEALTH SVS Response;2001-02***
8. Increase access to **attendant care** in clients' **homes and residences** (including SROs)	Additional capacity may be dependent upon increased funding; further assessment of client needs required
9. Better **integrate home health and medical care with substance use** providers, especially residential substance use facilities, to enable clients to stay in residential facilities.	Subcommittee has met to address identified issues; work group to continue meeting
10. Improve integration of decentralized **dental services with ISPs**	Coordination among dental and primary care programs via peer advocates needs further assessment. Currently available CARE Title I funded dental sites are: 2155 Webster, 470 Castro, 2460 Mission. Identify a dental provider with existing space & capacity in Tenderloin; South of Market Health Center has space and capacity. A recent grant was received by DPH ($170,000) for provision of dental services to any DPH client through TWHC; some service to be provided on site, some at shelters with portable equipment. DPH also provides dental care on campus at SFGH and in BVHP at SEHC.
12. Request that the **full range of complementary therapies** be provided at all CARE-funded primary care sites. In particular, acupuncture should be provided at all primary care sites.	SEE # 13
13. Better **integrate complementary therapy** with other services, especially substance use.	Hospital Sites remain problematic; hospital privileges for LAc requires DPH/PHP planning, lobbying, and negotiations with DPH/CHN and UCSF. Certain hospital policies may need to be changed. Letter mailed 10/5/00 from Council to Medical Staff Executive Committee of SFGH and Laguna Honda and copied to M. Katz, MD, Mabel Teng, and M. Welch, MD; no reply to letter.Three CARE contractors provide complementary therapy services at their own facilities. In addition several other agencies provide complementary therapy services through collaboration with CARE contractors or through other arrangements at the point of service; other arrangements include utilizing Medi-Cal reimbursement, State Funds, General Funds, In Kind Contributions, etc. These other agencies include some facilities that offer primary care and some that do not, i.e., MNHC, TWHC, MHHC, SEHC, HAFCI, Iris Center, WORLD, Continuum, Peter Claver, Leland House, Richard Cohen, Restoration House, Mano o Mano, Bay Positives, Walden House, API, and BVHPF.
13. Cont'd	Feasibility of expanding CARE funded sites is questionable without additional dollars. Recommendation: Contractors may decrease professional time spent with each client from 60 to 30 minutes and/or develop discharge plans for some clients that may no longer have high acuity levels, in order to offer services to clients currently on wait lists.

2001-02 ***OBJECTIVES***	***HIV HEALTH SVS Response:2001-02***
14. Using all available methods, continue to target all CARE-funded contracts to provide integrated services. Those integration's can be within organizations, among organizations, or both.	Three CARE contractors provide complementary therapy services at their own facilities. In addition several other agencies provide complementary therapy services through collaboration with CARE contractors or through other arrangements at the point of service; other arrangements include utilizing Medi-Cal reimbursement, State Funds, General Funds, In Kind Contributions, etc. These other agencies include some facilities that offer primary care and some that do not, i.e., MNHC, TWHC, MHHC, SEHC, HAFCI, Iris Center, WORLD, Continuum, Peter Claver, Leland House, Richard Cohen, Restoration House, Mano o Mano, Bay Positives, Walden House, API, and BVHPF. Feasibility of expanding CAREfunded sites is questionable without additional dollars. Recommendation: Contractors may decrease professional time spent with each client from 60 to 30 minutes and/or develop discharge plans for some clients that may no longer have high acuity levels, in order to offer services to clients currently on wait lists.
15. Address lack of **cultural sensitivity** to women, including those with children, transgender, and heterosexuals	The May 2000 AETC training on transgender issues was well received and well attended. A DPH Cultural Competency training (policy 24) to address women with children, heterosexual and transgender issues, among others, will be announced. Subcommittee of contractors and HIV Health Services staff prepared Title IV application to improve service to women and families; Lead agency was UCSF. CARE contractors working group is continuing its activities; Planning Council updated at 2/26 meeting
16. Train current **dental providers** on HIV care to expand pool of available providers	UCSF will conduct on-site community clinic based dental training; AETC will work together with the UCSF dental school and will provide on-site training to community dental clinics as requested and directed (possible first site is SEHC) A dental standards workgroup was created in February 2001 consisting of providers, county representatives (Alameda, San Francisco, San Mateo, Sacramento), and HIV dental specialists. This group has received a small HRSA technical assistance grant to develop HIV standards and clinical guidelines for HIV dentistry; standards to be finalized by 8-1-01

Draft Goals and Objectives for 2002-03

Health Care Goal	Objectives	Who	What	When	Funding Source
Goal #1 Provide health care to: 40% of those PLWH who are not in care by the year 2002-03	A. Identify all PLWH's not in care in the EMA.	Planning Council, HIV Health Services, HIV Provider Network, and Consultant	Needs Assessment to define and find PLWH "not in care"	Before 3.02	01-02 100k of Rollover Dollars
	B. Program planning and design.	Planning Council, HIV Health Services, HIV Provider Network, and Consultant	Analyze results of assessment done 01-02	02-03	Planning council Support Budget, State monies, General fund monies, Rollover dollars,
	C. Implement programs to find and keep PLWH's in primary care	Planning Council, HIV Health Services, HIV Provider Network, Consumers	RFP's for new programs and increase funding to current providers for capacity building	03-04	CBC dollars General Funds State Funds
Goal #2 Provide access and choice in Dental Providers	A. Continue to evaluate effectiveness of new contracts to provide decentralized Dental care.	Planning Council Hiv Health Services	Evaluation of new decentralized contracts.	02-03	May need program support or grantee dollars to assure that decentralized care is really occurring.
	B. Maximize use of other funding streams for dental care, especially Medi-Cal and TITLE F reimbursement.	HIV Health Services	Presentation to Council re steps taken to assure maximization of Title F and Medi-cal streams of funding	01-03	No dollars needed.

Goal #3 Continue to foster collaboration and integration between primary care, substance use and mental health services.	A. Continue to convene the primary care, substance use and, mental health task force to make recommendations about how these groups may more effectively interact.	Planning Council Task Force HIV Health Services Consumers	Report from Task Force with recommendations and action plan.	02-03	Evaluate funding when recommendations available.
	B. Report to Council on recommendations of Task force	Planning Council Task Force HIV Health Services Consumers	Evaluation of recommendations by Evaluation and Implementation Committee	02-03	Funding recommendations will be made for 03-04-budget cycle.
Goal #4 Maximize appropriate social assistance to clients to ensure participation in Primary Care.	A. Complete Case management, peer and treatment advocacy and practical support assessment.	Planning Council HIV Health Services Consultant Consumers	Evaluation of recommendations by Evaluation and Implementation Committee	02-03	Funding recommendations will be made for 03-04-budget cycle.

Goal #5 Evaluate feasibility of fully integrating Complementary Therapy as a health care option in a declining funding situation.	A. Evaluate use of Complementary Therapy as a health care option by the targeted underserved populations of Ryan White.	Planning Council HIV Health Services Consumers	Determine how many severe need clients are utilizing Complementary Therapy and make recommendations to council for this population. Include this in "not in care" assessment to determine who is using Complementary cares as Primary care and therefore not considered in care.	01-03	Funding recommendations may be made for 02-03-budget cycle.
Goal #6 Continue to address lack of cultural sensitivity to women (especially those with children), transgenders, and heterosexuals.	A. Continue to work with consumers to determine the ways that we can make services more sensitive to the needs of all PLWH's.	Planning Council HIV Health Services Consumers HIV Providers	Assist PLWH Caucus in formulating standards of care for the EMA that reflect sensitivity.	01-03	Will need 30 k of rollover dollars from 00-01 budget to determine what cultural sensitivity really is and how to make it part of the contracts.
Goal #7 Assure quality of primary care provided to all PLWH's.	A. Implement a Quality management program through the DPH that assures that Title 1 providers are meeting primary care standards of care.	HIV Health Services AETC Planning Council Consumers SF HIV/AIDS Provider Network	Work with HIV Health Services to determine best method for assessing quality of care using quality management techniques.	01-03	60 k from 00-01 Rollover funds to begin process. Determine appropriate methods to implement quality management in 02-03. Then assist HIV Health Services in implementing quality management programs.

Housing Goal	Objectives	Who	What	When	Funding Source
Goal #1 Maintain and improve current housing stock	A. Ensure existing housing stock is not reduced. *	Planning Council, HIV Health Services, SF City and County	Allocate funds to support existing housing subsidies jeopardized by increases in FMRs and housing costs.	Immedia te	$250k of Rollover Dollars Reallocation of funds for ongoing support or funds from other sources.
	B. Advocate for increased building code compliance and enforcement by gaining Council seat on the SRO Task Force.	Planning Council, Mayor's office	Gain appointment to seated task force for planning council member.	02-03 or sooner	No funds required.
Goal #2 Promote housing stabilization	A. Increase emergency resources available for security deposits, utilities, and back rent.*	Planning Council Hiv Health Services	Short term or ongoing augmentation of emergency financial resources/ eviction prevention.	02-03 and/ or sooner	Up to $213k Rollover funds for one-time support Reallocation of funds for ongoing program
	B. Increase legal advocacy for eviction prevention.	Planning Council Hiv Health Services	Short term or ongoing augmentation of legal services contracts to focus on housing issues.	02-03 and/ or sooner	Up to $40K Rollover funds for one-time support Reallocation of funds for ongoing program
	C. Ensure all housing assistance programs include a strategy which focuses on shifting clients into or maintaining stable housing.	Planning Council Hiv Health Services	Changes in contract language to support program goals of encouraging stable housing. (may already have been achieved)	02-03	No funds required.

	D. Provide appropriate staffing to respond to the higher level of needs in the Harm Reduction environment.	Planning Council HIV Health Services	Increase staffing levels in residential facilities.	02-03	$? Reallocation of funds for ongoing support.
	E. Educate and train staff who are working with active users.	HIV Health Services AETC?	Provide training to staff at hotels with blocks of emergency rooms in harm reduction strategies and program goals.	Before 3/02 or later	$10k Rollover funds
Goal #4 Broaden available housing opportunities	A. Increase resources for master leasing of buildings with on-site integrated support services, including medical care. *	Planning Council HIV Health Services SF City and County	Allocate funding to support expansion of emergency housing program or development of new housing program initiatives.	02-03	$? Reallocation of funds CBC funds Reallocation of funding within health care category or within other support services.
	B. Expand number of rooms available for Emergency Voucher blocks. *	Planning Council HIV Health Services SF City and County	Allocate funding to support expansion of emergency housing program or development of new housing program initiatives.	01-02 and/ or 02-03	$? Rollover funds (temporary expansion) CBC funds Reallocation of funds for ongoing program.
	C. Pursue more collaborative housing projects with other funding sources..	Planning Council HIV Health Services SF City and County	Support DPH Housing in leveraging multiple funding sources and collaborations for development of new and ongoing housing program initiatives.	ongoing	No funds required.
	D. Prioritize HOPWA funds for capital projects rather than ongoing support services.	Planning Council SF Redevelopment Agency	Encourage SF Redevelopment Agency to seek replacement funding for support services, in order to free HOPWA funds for development of capital projects.	ongoing	No funds required for current policy recommendation- may eventually require reallocation of funds.

2001-02 ***Priorities***

4.Improve **integration of all housing assistance funds**, including direct emergency financial assistance, and other emergency housing assistance funds, with the goal of coordinating available resources to maximize effectiveness in establishing residency and stability.

5.Expand **decentralized access to emergency housing vouchers** and shallow rent subsidies through expanded integrated services network, including DPH clinics, case management and peer advocacy programs, and at drop-in centers, and agencies serving persons in housing crisis (such as ALRP), also including after hours availability.

6.Use emergency vouchers to **block out** a **number of rooms** in one hotel.

7.Implement **centralized complaint and tracking system**

8.Educate/Provide emergency hotel staff about/with housing programs and available support services, such as crisis intervention and practical support and that it be multicultural with multiple translations available.

9.Initiate **team inspections** with staff from DBI, DPH, DHS, SFFD, and Emergency Housing Program Staff, with the goal of increasing code compliance and enforcement.

12.Direct DPH Housing Unit to identify additional funding for **shallow rent subsidies.**

13.Redirect resources to **master leasing** of buildings, sublet with on site integrated support services, including primary care. Project-base portion of subsidies.

14.Support **harm reduction** ~~model housing~~ training for residential staff working with active users. (Housing committee suggests we change language to educating staff since no money available for new housing at this time.)

~~15.Integrate housing assistance funds including both emergency and subsidy funds with other services, and other sources of housing assistance to provide on site integrated services in congregate supported housing. Identify vacant buildings which could house integrated service models, including co-locating primary care and supported housing, to help stabilize unstable clients.~~

16.Expand **decentralized** access - expand link to emergency housing

19.Increase **legal advocacy for eviction prevention**. Make emergency housing and direct emergency financial assistance funds, including eviction prevention funds, available at legal advocacy sites.

20.Create **outreach and advocacy training program** for clients searching for housing, and for peer advocates helping clients find housing

21.Improve **conditions in SRO's** used for emergency and transitional housing through coordinated efforts between providers and the DPH.

22. Improve outreach to **homeless people** living with HIV/AIDS.

23. Ensure existing stock of housing is not reduced. (new priority added 3.00 by Housing Committee)

24. Implement recommendations from Emergency Housing Task Force (new priority added 3.00 by Housing Committee)

25. All housing assistance programs must include a strategy that aims to transition into or maintain stability in housing

26. Provide training to all care-funded providers around eviction preventions and legal advocacy for tenants

HIV Health Services Planning Council

25 Van Ness Ave. Room 330-A

August 13, 2001 4:30 PM

AGENDA

I.	**Call to order**	4:30 PM
II.	**Roll Call**	4:32 PM
III.	**Review and Approval of Agenda**	4:34 PM
IV.	**Review and Approval of Minutes,** 7/9 — **VOTE**	4:36 PM
V.	**General Announcements**	4:38 PM
VI.	**Public Comment**	4:41 PM
VII.	**Reports**	
	• *Membership Committee* — **VOTE**	4:48 PM
	• *Service Category Discussions of Goals & Objectives*	4:55 PM
	- Housing — **VOTE**	5:00 PM
	- Food — **VOTE**	5:25 PM
	- Substance Abuse — **VOTE**	5:30 PM
	- Mental Health — **VOTE**	5:50 PM
VIII.	**Break**	6:00 PM
	- Client Advocacy — **VOTE**	6:10 PM
	- Case Management — **VOTE**	6:15 PM
	- Day & Respite Care — **VOTE**	6:30 PM
	- Transportation — **VOTE**	6:35 PM
	- Planning Council Support — **VOTE**	6:40 PM
	- Program Support — **VOTE**	6:55 PM
	- System-Wide Goals & Objectives — **VOTE**	7:00 PM
IX.	**New Business**	7:20 PM
X.	**Adjourn**	7:30 PM

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Thurs	8/16	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Thurs	8/16	Prioritization Organizing Comm.	25 Van Ness, 5th fl. Conf. Rm.	5:30 – 7:00 PM
Mon	8/27	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	9/5	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	9/5	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
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Memo

Friday, August 03, 2001

Please make note of the location for the next Council meeting: It's in Room 330-A at 25 Van Ness Ave. The Mayor's Conference Room in City Hall was unavailable.

This mailing is going out today in order to give added emphasis to the importance of the planned discussions about Goals and Objectives. Sending the enclosed Draft early, gives members a little extra time to analyze the proposed Goals and Objectives and prepare for the discussions that will take place.

Please find enclosed a copy of the goals and objectives, which were approved at the July 23rd Council Meeting, and a copy of the Draft goals and objectives, which will be voted on at the August 13th Council meeting.

Early next week another mailing will be sent to you containing the past meeting Minutes and Committee Reports.

Steve

Approved Goals and Objectives for 2002-03

Existing resources:	to be done within scope of existing programs and resources
Rollover:	during FY 01-02 with rollover or "unfunds" from FY 00-01
Increased funding:	only if increased Title I funding or funding available from another source (e.g. new grants)
CBC:	to be funded with new CBC/MAI funds, for people of color
Move funds:	move current resources out of existing programs for this
Other funding:	other funding stream identified

HEALTH CARE

Goal	Objectives	What	When	Funding Implication
Goal #1 Provide health care to: 40% of those PLWH who are not in care by the year 2002-03	A. Identify all PLWH's not in care in the EMA.	Needs Assessment to define and find PLWH "not in care"	Before 3.02	Carryforward: $100K
	B. Program planning and design.	Analyze results of assessment done 01-02	02-03	Increased funding; Existing resources
	C. Implement programs to find and keep PLWH's in primary care	RFP's for new programs and increase funding to current providers for capacity building	03-04	Increased funding; CBC dollars
Goal #2 Provide access and choice in Dental Providers	A. Continue to evaluate effectiveness of new contracts to provide decentralized Dental care.	Evaluation of new decentralized contracts.	02-03	Existing resources
	B. Maximize use of other funding streams for dental care, especially Medi-Cal and TITLE F reimbursement.	Presentation to Council re steps taken to assure maximization of Title F and Medi-cal streams of funding	01-03	No dollars needed.

Goal #3 Continue to foster collaboration and integration between primary care, substance use and mental health services.	A. Continue to convene the primary care, substance use and, mental health task force to make recommendations about how these groups may more effectively interact.	Report from Task Force with recommendations and action plan.	02-03	Evaluate funding when recommendations available.
	B. Report to Council on recommendations of Task force	Evaluation of recommendations by Evaluation and Implementation Committee	02-03	Funding for 03-04-.
Goal #4 Maximize appropriate social assistance to clients to ensure participation in Primary Care.	A. Complete Case management, peer and treatment advocacy and practical support assessment.	Evaluation of recommendations by Evaluation and Implementation Committee	02-03	Funding for 03-04-.

Goal #5 Evaluate feasibility of fully integrating Complementary Therapy as a health care option in a declining funding situation.	A. Evaluate use of Complementary Therapy as a health care option by the targeted underserved populations of Ryan White.	Determine how many severe need clients are utilizing Complementary Therapy and make recommendations to council for this population. Include this in "not in care" assessment to determine who is using Complementary cares as Primary care and therefore not considered in care.	01-03	Increased funding
Goal #6 Continue to address lack of cultural sensitivity to women (especially those with children), transgenders, and heterosexuals.	A. Continue to work with consumers to determine the ways that we can make services more sensitive to the needs of all PLWH's.	Assist PLWH Caucus in formulating standards of care for the EMA that reflect sensitivity; determine what cultural sensitivity really is and how to make it part of the contracts.	01-03	Carryforward: $30K
Goal #7 Assure quality of primary care provided to all PLWH's.	A. Assist in implementing a Quality management program through the DPH that assures that Title 1 providers are meeting primary care standards of care.	Work with HIV Health Services to determine best method for assessing quality of care using quality management techniques. Determine appropriate methods to implement quality management in 02-03. Then assist HIV Health Services in implementing quality management programs.	01-03	Carryforward: $60 k

OVERALL

Goal #2 To create a more truly "Client Centered" system of care.	1. Provide more training to providers working with "severe need" populations on culturally appropriate service delivery models.	1 training on each severe need group: Homeless Substance use Mental Health Women Transgenders Hepatitis C Doubly and triply diagnosed clients.	02 – 03	Other funding: AETC training budget
	2. Include an evaluation of culturally appropriate or sensitive behaviors in the quality management assessment of providers.	Define behaviors that can be measured to indicate adequate competency in severe need populations.	02 – 03	Move funds: $50k into Quality Management
	3. Expand Integrated Service Category to be sure that programs include substance use and mental health services.	Request that HHS report to the council on what services need to be included in an ISP in order for it to be truly integrated (one stop shopping)	02 - 03	Move funds: $50K each from case management (stand-alone), Mental Health, and substance use.
	4. Expand Integrated Services model throughout the system of care, including the development and delivery of multi-lingual services.	Assist HIV Health Services to define what a fully integrated model of care includes.	02 - 03	CBC

PLANNING COUNCIL SUPPORT

Goal #3 To Strengthen the PWA Caucus	1. Provide immediate resources for PWA Caucus to enhance leadership development, etc.	Hire consultant to assess needs of the Caucus and begin the development of leadership skills, etc. Consultant will assist the Caucus in creating a two-year work plan.	Project to be completed by 2/02	Carryforward: $5K
	2. Increase Council Support budget to include a budget line item for activities that support the PWA Caucus such as	Ongoing support for the continued development of mentoring, leadership, facilitation skills, etc. Evaluate progress on 2-year plan.	02 – 03	Existing resources: $10K in Council Support Budget

	mentoring, facilitation, leadership development, etc.			
	3 The PWA Caucus will work in collaboration with the Membership Committee to advise the Council on the issue regarding the "outreach" line item in the Council Support budget.	In collaboration with the Membership Committee, evaluate the most effective use of outreach dollars. Create outreach plan.	01 – 02	Existing resources: $7,350 Council Support Budget

Running totals

Carryforward: $195K
Move funds: $200K
CBC:
Increased:

DRAFT GOALS AND OBJECTIVES FOR 8/13 MEETING

Funding Terms

Existing resources:	to be done within scope of existing programs and resources
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Increased funding:	only if increased Title I funding or funding available from another source (e.g. new grants)
CBC:	to be funded with new CBC/MAI funds, for people of color
Move funds:	move current resources out of existing programs for this
Other funding:	other funding stream identified

Housing

Goal	Objective	What	When	Funding
Maintain and improve current housing stock	A. Ensure existing housing stock is not reduced.	Allocate funds to support existing housing subsidies jeopardized by increases in FMRs and housing costs.	02-03	▪ *$400K+ estimate* ▪ Move funds OR Other funding
	B. Advocate for increased building code compliance and enforcement by gaining Council seat on the SRO Task Force.	Gain appointment to seated task force for planning council member.	02-03 or sooner	Existing resources
	C. Maintain quality of existing housing programs	Allocate rollover funds to pay for repairs, goods, and services.	01-02 02-03	▪ $200K Rollover ▪ Potential rollover request for 02-03
Promote housing stabilization	A. Increase resources available for emergency housing costs such as security deposits, utilities, and back rent, prioritizing people "not in care"	Short term and ongoing funding for emergency financial resources related to housing, including eviction prevention	02-03 and/ or sooner	• 100K Rollover • 100K Move funds for ongoing program
	B. Increase legal advocacy for eviction	Short term or ongoing augmenta-	02-03	• 15K Rollover

	prevention.	tion of legal services contracts to focus on housing issues.	and/ or sooner	• 30K Move funds • Ensure that previous funds have been disbursed.
	C. Ensure all housing assistance programs include a strategy which focuses on shifting clients into or maintaining stable housing.	Continue to use contract language to support program goals of encouraging stable housing.	02-03	Existing resources
	D. Provide appropriate staffing to respond to the higher level of needs in the harm reduction environment.	Increase case management and clinical support staffing levels in large residential facilities.	02-03	200K Move funds for ongoing support.
	E. Educate and train staff who are working with active users.	Provide training to CARE funded providers regarding housing active users; including, training in harm reduction strategies.	02-03	Add to Program Support scope of work. Estimate $10k
Broaden available housing opportunities	A. Increase resources for master leasing of buildings with on-site integrated support services, including medical care.	Allocate funding to support expansion of emergency housing program or development of new housing program initiatives.	02-03 03-04	▪ Potential rollover in 02-03 for start-up ▪ Potential need for new funds in 03-04
	B. Expand number of rooms available for emergency housing	Allocate funding to support expansion of emergency housing program or development of new housing program initiatives.	02-03	250K move funds for ongoing support.
	C. Pursue more collaborative housing projects with other funding sources.	Support DPH Housing in leveraging multiple funding sources and collaborations for development of new and ongoing housing program initiatives.	ongoing	Existing resources
	D. Prioritize HOPWA funds for capital projects rather than ongoing support services.	Collaborate with San Francisco Redevelopment Agency and the Mayor's Budget Office to seek replacement funding for support services, in order to free HOPWA funds for development of capital projects.	ongoing	Potential future reallocation of CARE funds and new allocation of non-CARE funds.

Food

Goal	Objective	What	When	Funding
All people with HIV will have adequate food and nutrition to improve health status.	Ensure food services support increased access to care.	Provide food vouchers to agencies to help bring people into care and retain them in care.	02-03	Rollover: $70K

Mental Health

Goal	Objective	What	When	Funding
Improve the mental health and quality of life of uninsured and underinsured PLWH, in order to increase their ability to access medical care.	Respond to increased need for Psychiatric Emergency Services for PLWH.	Develop intensive case management component of HIV mental health crisis services.	02-03	Rollover for planning. Increased funds for implementation

Substance Abuse

Goal	Objective	What	When	Funding
Improve health status and quality of life of uninsured and underinsured PLWH through substance abuse treatment in order to increase their ability to access medical care.	A. Increase Spanish language capacity in residential and outpatient programs.	Prioritize Spanish-language capability for substance abuse treatment hiring.	02-03	Contract language CBC funding
	B. Increase cultural competency with La-	Integrate analysis of cultural and	02-03	Integrate into QM

	tino populations, female clients, and transgender clients in residential and outpatient programs.	linguistic competencies into QM plan. Implement training as indicated by analysis.		Plan Training funds from program support.
	C. Assess level of need for substance abuse treatment for HIV+ women with children.	Conduct assessment of need for substance abuse treatment for HIV positive women with children. Coordinate with existing assessments.	02-03	Integrate into needs assessment: rollover funding.

Client Advocacy

Goal	Objective	Activity	Time	Funding
Increase access to care for PLWH through client advocacy.	Ensure clients are receiving benefits screenings and increased benefits when eligible.	Evaluate ongoing efforts to increase benefit screenings through contract monitoring.	02-03	Existing resources
	[see legal advocacy objective under housing]			

Case Management

Goal	Objective	What	When	Funding
Increase access to care for PLWH through coordinated and integrated case management.	A. Increase integrated case management services and peer and treatment advocacy for people of color	Use CBC funding to increase service capacity at people of color community based agencies.	02-03	CBC funding
Ensure case management services are cost effective and high quality	A. Monitor duplication of case management services to ensure cost-effective use of resources.	Utilize Reggie data, networking mechanisms and practices among providers, and AIDS office monitoring programs to monitor case management duplication.	ongoing	Integrate into QM project.
	B. Develop standards of care for peer advocacy	Follow recommendations from CM/PA/TA report.	01-02	Integrate into QM program.

	C. Develop standards of care for treatment advocacy	Follow recommendations from CM/PA/TA report	01-02	Integrate into QM program.
	D. Evaluate ISP Model	Develop standards for composition of ISPs, evaluate effectiveness, consistency, and efficiency of service delivery comparing integrated and stand-alone models.	02-03	Integrate into QM program.
	E. Support implementation of standards of care when completed for Peer Advocacy, Treatment Advocacy, CM Coordination.	Disseminate, train on, and evaluate adherence to standards of care when completed.	02-03	Integrate into QM program.

Day & Respite Care

Goal	Objective	Activity	Time	Funding
All people with HIV will have the day and respite care they need to access health care and other services.	Outreach to 100 families with HIV/AIDS with information about availability of respite child care to increase utilization of respite child care services	Provide information to CBC-funded and other outreach workers on the availability of childcare services and how to refer families to it.	**02-03**	CBC Existing resources

Transportation

Goal	Objective	Activity	Time	Funding
People with HIV have adequate transportation to medical and service appointments and programs.	People with HIV can use public transportation to get to and from appointments.	Provide bus vouchers to low income and disabled PLWH	**02-03**	Rollover: $25K

Planning Council Support

Goal	Objective	Activity	Time	Funding
The Planning Council will conduct its activities effi-	A. The Planning Council conducts		**02-03**	Existing resources

ciently and effectively and fulfill all mandated roles and responsibilities.	monthly Council and committee meetings			
	B. The Planning Council meets membership requirements and expectations.	Membership Committee assesses membership needs, and recruits, selects, and nominates new members.	**02-03**	Existing resources
	C. All Council members are trained in the core competencies identified by HRSA.	The training plan is developed, implemented and revised as needed, with ongoing training for Council members, and all new Council members are oriented and trained within 30 days of their appointment.	**01-02** **02-03**	Rollover: $10K Existing resources
	D. The Planning Council completes a comprehensive needs assessment with a focus on people not in care by May 2002	Needs assessment work group and consultant are identified and assessment is designed and completed.	**01-02** **02-03**	Rollover: $150K
	E. The Planning Council completes its 3-year plan by September 2002.	Planning work group and consultant are identified and plan is developed in compliance with HRSA expectations.	**02-03**	Existing resources
	F. The Planning Council leadership and staff complete all relevant Conditions of Award in a timely manner.	Co-chairs and staff write and sign letters and produce other documentation for HRSA as needed.	**02-03**	Existing resources
	G. Increase effectiveness of Planning Council support	Investigate other models of support and assess current support structure and revise as needed.	01-02	Existing resources

	H. Council staff fulfills all HRSA requirements and expectations as well as those defined by the Council.	The Council support staff produces timely and accurate minutes of all Council and committee meetings, and the Council meets all open meeting and notification requirements including timely posting of notices and minutes on the internet.		Existing resources

Program Support

Goal	Objective	What	When	Funding
CARE-funded providers receive the technical assistance needed to ensure the quality and effectiveness of the care and services provided to people with HIV/AIDS.	A. Prioritize training and technical assistance on quality management to health care providers in conjunction with quality management program.	Provide training to providers as needed on development and implementation of quality management	**02-03**	Move: $ into quality management
	B. Increase ability to serve multiply diagnosed people with HIV.	Provide training to providers on working effectively with multi-diagnosed clients.	**02-03**	Existing resources
Increase access to care by providing consumers with information about the services available.	A. Provide consumers with information on services and programs available.	Reprint updated service resource guide	01-02	Rollover: $10K

Overall or Systemwide Goals

Goal	Objective	What	When	Funding
Maximize access to health and financial benefits for people with HIV/AIDS.	Encourage benefits counseling programs to do outreach and provide services off-site as feasible.	Determine which programs should and could be doing outreach or providing services off-site.	02-03	Existing resources
Improve health status of women and families with HIV	Work with new Title IV program to eliminate gaps in the continuum of care for families with children		02-03	Existing resources
Bring people with HIV who know their status and are not in care into care	Agencies outreach to people with HIV not in care where appropriate and feasible	Determine which services and programs should and could be doing outreach or providing services offsite.	02-03	Existing resources
Increase access to client-centered care by expanding integration of services	A. Increase coordination of mental health, primary care, client advocacy, substance abuse, and case management at the program level.	Evaluate ongoing structures for communication between CARE-funded programs in different service categories; standardize, expand, and solidify current practices.	02-03	Rollover funds for planning. Increased funds for implementation
	B. Increase coordination of mental health, primary care, client advocacy, substance abuse, and case management at the administrative level.	Increase and improve communication and collaboration between HIV Health Services, CSAS, and CMHS.	ongoing	Existing resources.

Minutes, August 13, 2001 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at next meeting

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I. Call to Order
4:30 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
Catherine Geanuracos announced that this meeting might require extra time. She said that at about 7:00 PM there will be a time check and a possible vote to extend the meeting beyond the normal ending time of 7:30 PM. The Agenda was approved.

IV. Review and Approval of Minutes
7/9/01 Council Meeting Minutes – no changes were requested. By voice vote, the Council Meeting Minutes were approved. Several members abstained.

VI. General Announcements
CG thanked everyone who attended the extra meeting on July 30th in order to coordinate work more closely with the HIV Prevention Planning Council.

VI. Public Comment
Russ Zellers, AIDS Office, stated that the meeting between this Planning Council and the HIV Prevention Planning Council was an important event. He stated that collaboration between the two Councils would become increasingly important during the Prioritization process in future years. *RZ* said that a particularly important issue for planning has to do with HIV/STD prevention within the Health Services arena. He urged the Council to look at health services designed to decrease the transmission of HIV, due to the increasing number of people engaged in high-risk behaviors. He called for greater coordination between the two Councils and greater attention to prevention efforts among HIV+ populations that this Council serves.

VII. Reports

VIII. Membership Committee Report
Ken Pearce distributed an information sheet and reviewed the applicants that the Committee had endorsed for membership: *Dirk Doepfner, David Gant, Elyse Graham,* and *Kevin Johnson.* Additionally, *KP* said there were five more applicants under consideration and in various stages of the process for potential membership, which would help fill empty Council seats. Discussion turned to the percentage of Council members who are either HIV+ or consumers of CARE funded services. *Ken* said that out of the current roster, there are 19 HIV+ members (53%), and 12 consumers (33%). *Mjay Sanders* noted that the Council Bylaws require a total HIV+ membership of 67%. He asked how many HIV+ members would be recruited. *Laura Thomas* answered that based upon a full Council of 40 members there would be 27 HIV+ members and 16 of those would be non-affiliated consumers. *Mary Jane Wood* expressed a concern over disclosure of HIV status and what could be viewed as a violation of confidentiality. She said it might be possible to report from the Membership Committee to the Council without noting the categories of representation. The motion to approve the slate of nominees set forth by the Membership Committee was then approved by a unanimous vote. *MJW* also asked that attendance at meetings be recorded in two categories: full Council meetings and committee meetings.

IX. Service Category Goals and Objectives
The meeting was turned over to facilitator, *Monika Hudson.* She handed out drafts of Goals and Objectives for the various service categories, as well as the agreed-upon goals and objectives for the

Health Care category that had been hammered out at the previous meeting on July 23rd. While members were examining the content of these handouts, Monika asked Laura Thomas to briefly explain the grid format and demonstrate how she would be making revisions to these documents on her laptop computer, which would be simultaneously projected on the screen at one end of the room. Allocations and funding issues were not to be discussed during this meeting. That was to be the subject for the meeting two weeks later. Tonight was designed to be the necessary groundwork because the discussion would establish agreements on what would be accomplished during the upcoming year. She clarified that "carry-forward," "rollover funds," and "Unfunds" were different terminology for basically the same thing: funds that were not used in the past fiscal year that are now available, with HRSA approval, to be used in the current year. This concept would become even more relevant in the discussion of funding/allocations to be held next meeting, but it was suggested that the Council agree on terminology. "Rollover funding" was considered the best term, at least for the portion of "Unfunds" related to the current discussion. Laura also said that the same or similar goals and objectives had been suggested for several service categories. After seeing this repetition the Prioritization Organizing Committee had thought it better to include in the overall workplan a number of system-wide goals and objectives. This would be the final category to be considered.

X. Goals and Objectives for Housing Services

Laura Thomas reviewed the draft language, mostly developed out of discussion in the Housing Committee. *Sam Kaplan* asked about emergency housing for people "not in care." *Margot Antonetty* responded by mentioning contract language that will be included in next year's contracts in order to insure access by this group of clients. *MJW* said that these goals and objectives seemed to plan for increased funding, a prospect that might necessitate taking a significant amount of money away from other service categories. *Susan Shea* did not agree that the language of the Housing goals and objectives was problematic. She saw the Housing goals and objectives as containing broad language. *MA* agreed and said that plans for implementation of goals and objectives will follow. *Jeff Byers* said he felt that goals and objectives might gain support, while funding is a separate issue and may not be available in all cases. *Jose Villarce* strongly supported the Housing goals and objectives. It was moved to "call the question." No one objected to ending the discussion. A motion was made to approve the Housing goals and objectives as written. This motion was agreed to *(see Roll Call sheet, Column 2).*

XI. Goals and Objectives for Food

The goal and objective for this category was presented. *Laura Thomas* said that the generic wording was intended to address the need to use Rollover funds for food vouchers that will be distributed through service providers. She noted that current services would continue. *Donald Frazier* suggested that the wording might be more specific in regards to serving primarily HIV+ populations not currently in care, or alternatively being clear about wanting to serve all eligible clients. *SS* stated that the phrasing was appropriate in that it would allow the Council to use funding in various ways designed to increase access to health care. *Marc Dunlop* noted that this phrasing allowed for the inclusion of those not in care as well as those currently receiving care. The question was called. No one objected to cutting off discussion of this topic. A motion to approve was passed unanimously *(See Roll Call sheet, Column 3).*

XI. Goals and Objectives for Substance Abuse

The goals and objectives were reviewed for this service category. *CG* said that the objectives under Substance Abuse were drafted with input from providers, consumers, and DPH staff in order to address the gaps that exist in the services. As with other categories, these goals and objectives were finally put together and presented by the Prioritization Organizing Committee. Some members had questions about the process: to what extent consumers were involved and to what extent any groups functioned as the Housing Committee did developing goals and objectives. These issues were clarified. *Bart Casimir* suggested that the language about "health status" include accessibility and quality of life for uninsured and under insured. *DF* questioned the language about increasing cultural competency in one of the

objectives. He asked if Policy 24, in which all agencies with city and county contracts are participants, already provides a level of cultural competency to services. He wondered how this could be increased further. *Margot* answered that while Policy 24 is a part of current policy, it is often difficult to add additional cultural competency services without additional funding. *MJW* suggested a change in language that was noted on the computer and screen. Some suggestions came forward for improving this "cut and paste" method. *Jeff Byers* returned to the particular objective intended to expand upon the existing cultural competency mandates for agencies to follow and asked others to explain how this issue is handled in provider's contracts. *Michelle Long Dixon* explained how compliance is monitored with reference to cultural competency and stated that specific cultural competency issues appropriate for individual agencies might be implemented to fulfill contractual requirements. Some specific cultural competency issues were referenced, such as the language in which service is available, or the accessibility of transgender-specific services. *CC* wanted to clarify the goal of substance abuse treatment services as being improved health status. *SS* suggested wording for the goal in order to focus on medical care. *Fernando Gomez-Benitez* also suggested wording. *Brad Hume* motioned for a vote on the language of this goal: Improve access to substance use treatment to increase access to health care to improve health status and quality of life for uninsured and underinsured people living with HIV/AIDS. A voice vote was taken on this goal, and it was unanimous.

Next, the Council reviewed the objectives under this goal. *DF* made a suggestion of substitute language for one of the Substance Abuse objectives so it was more encompassing and not population specific, especially in one objective that had been focused on the Latino community. *MA* mentioned the specific needs she had heard articulated in presentations about this service category and preferred the language as written. *FGB* talked about how difficult it is to find services for Latinos and Transgenders seeking Substance Abuse treatment. *Wayne Peace* spoke against the substitute language because he recognized specific needs in the two communities (Latino & Transgender). *SS* spoke in favor of specific targeting of services. *Jim Mitulski* suggested a compromise in wording for this objective, wishing to add two additional groups, African American & Homeless. *Larry Cruz* welcomed the specific focus on certain communities. This was in the spirit of information presented to the Council. *Jose Villarce* said he wanted to be true to the input received about specific needs among specific communities. *Carmen Madriz* talked about the difficulty she has as a social worker trying to place clients in programs. She recognized the lack of substance abuse treatment services for some populations. A lot of agencies were unable to handle even client intake, let alone treatment, in Spanish. All of these speakers were recommending the language as originally written. Some speakers, however, felt that other People of Color communities and Homeless populations had to be specifically addressed in these objectives. *DF* pointed out the relative lack of services and a total lack of testing services, in specific neighborhoods, Bayview Hunter's Point and Visitation Valley. He supported the need for specific service components to the Latino community, and then talked about similar needs in the African American community. An attempt was made to "call the question," but this was objected to. A voice vote was evenly divided. A Roll Call vote showed that more discussion was desired *(See Roll Call, Column 4)*. *LC* said the proposed re-wording would make this objective into a political statement rather than programmatic. He said that trying to include all possible groups would make the objective meaningless from a programmatic standpoint. *FGB* suggested compromise wording.

CG stated that the objectives were designed based on the information about gaps in services that was presented to the Council. She did not want umbrella statements that would overshadow the initial objectives. *Jeff Byers* spoke in support of *CG* and also expressed concern about another objective and suggested that cultural competency was a system-wide objective. *WP* asked that the Council remember that these initiatives were for the upcoming fiscal year and not permanent items. *MA* stated that if necessary, the Council could refer to its definition of "Severe Need" to establish the highest priority efforts, mainly outreach efforts. *CC* supported what Margot put forward in the form of a motion. The question was called. A voice vote was taken. The majority was in favor, and three members were opposed to stopping debate. It was agreed to proceed first to a vote on compromise wording: this

substance abuse objective would read: *Ensure cultural competency for people living with HIV specifically people of color and transgender clients in residential/outpatient programs.* The motion failed *(See Roll Call sheet, Column 5).*

XII. Break

A motion was introduced by *Jim Mitulski* to extend the meeting until 8 PM. The motion was seconded. A show of hands was in favor of the extension. *Monika Hudson* asked that the members put suggestions in the form of motions to expedite the proceedings. The topic of Substance Abuse and the language for stating objectives was continued. The original motion as presented by the group was reintroduced. *WP* made a motion to accept the language as it was originally presented by Prioritization. That motion was seconded. The question was called and seconded. The motion passed 17-5 with one abstention *(See Roll Call sheet, Column 6).*

XIII. Goals and Objectives for Mental Health

Laura Thomas read the wording for this service category. A slight modification was made in the wording of the objective: *Janis Takamoto* stated that the language of the objective indicated that services would be limited to hospital care. Therefore, she made a motion to change the phrase "Psychiatric Emergency Services" to lower case letters so that it is more generic. Some members wanted to proceed directly to a vote without further discussion; others opposed "calling the question." By a voice vote it was decided to end debate and proceed to a vote to approve this goal and objective by a vote of 19-3 *(See Roll Call sheet, Column 7).*

Jeff Byers cautioned members about jumping to "call the question." He made a motion to reconsider the vote because there was confusion as to what the Council was voting on. *DF* said that he shared the confusion and added a complaint about the prior item under Substance Abuse being voted upon hurriedly at a time when he was out of the room. The motion to reconsider was seconded. *Monika* asked if there was opposition to this motion. She noted one member in opposition, so ruled in favor of reconsideration of the Mental Health objective. *MJW* made a motion to change the language of the objective to read: Respond to increased need for mental health emergency services for persons living with HIV. The motion was seconded. *KP* disagreed with the interpretation of psychiatric emergency service as only being provided by Psychiatrists and challenged MJW to convene a sub-committee of the Council that he said had not met in two years. *MJW* responded by reminding the Council that it had been decided as part of the Prioritization process to conduct these discussions in the Council as a whole rather than in sub-committees. *Monika* noted that this may be a topic for consideration next year, but that she saw many members indicating their agreement with MJW's interpretation of the process this year. *Gary Harrell* spoke in favor of the revised language. *WP* asked for a definition for mental health. *MJW* clarified her motion to include licensed mental health providers. *BC* made a friendly amendment, subsequently re-worded by other members, to the language of the objective: Respond to increased need for psychiatric crisis and emergency services provided by licensed professionals for people living with HIV/AIDS. *KP* objected to this wording because he pointed to a significant population of triply diagnosed individuals who needed access to mental health services, but may not seek out "crisis" services related to their HIV. *BH* related a personal experience with seeking out psychiatric services. He said there is a definite need for crisis-oriented services. *MJS* said the population needing help in the mental health arena did not necessarily see themselves "in crisis." Everyone then agreed on compromise wording of the objective, as written above, including the words "crisis" and "emergency." *Edward Patterson* wanted clarification on the term "licensed professionals." *MJW* responded that an agency may be licensed but the employees may not be licensed. With the level of need being discussed here, she wanted the service to be provided by not just a licensed agency but also licensed professionals. *EP* opposed that language. *JT* said that the clients who become involved in a crisis through an agency, may be helped by social workers, who may or may not be licensed. *Laura Thomas* provided some background perspective, saying that there was already a funded range of mental health

service, which will be continued. She said this objective was not intended to cover all the contingencies for all population segments. *JV* mentioned the number of people providing mental health services who are in training for their licenses. *CG* called the question, and it was seconded. The Council proceeded to vote on the goal and the objective for the Mental Health category. It passed 14-7 with two abstentions *(See Roll Call sheet, Column 8)*. There was a lack of clarity concerning circumstances and rules for abstention. A Co-Chair said they would report to the Council with clear information on this issue.

XIV. Goals and Objectives for Client Advocacy

Monika reviewed the goal and objective in this category. It was asked if appropriate screenings for potential benefits were currently happening. *Laura Thomas* responded affirmatively and added that there was a desire to see this work continue. *WP* asked why the wording of the objective calls for an increase in this service. *CG* asked him to focus just on the objective, without even considering the availability of funds to support such an increase. *JB* clarified that the Council was not dealing with funding, only programmatic issues. That meant service providers in this category can vote without reference to any conflict of interest. The Council proceeded to take a voice vote on this category, with unanimous approval.

XV. Goals and Objectives for Case Management

Monika again reviewed the goals and objectives in this category. *SS* motioned to accept this set of goals and objectives as written. *BH* mentioned the input from consumers related to this category, including references to duplication of service and the need for more support to ISPs (Integrated Service Providers). No additional comments or questions came forward. Thus, the Council proceeded to a voice vote, with unanimous approval.

XVI. Goals and Objectives for Day and Respite Care

Monika once again reviewed the goal and objective in this category. *SS* motioned for an amendment to the wording of the objective related to outreach, specifically to 100 families in collaboration with the new Title IV project. *GH* asked where the number, 100, was derived from. He preferred being less specific. *Laura Thomas* responded that there was a desire to include measurable objectives where appropriate. *LC* noted that most of the other objectives did not include specific numbers. No one else indicated a desire to speak on this category. So, a voice vote was taken, and received unanimous approval.

XVII. Goals and Objectives for Transportation

Monika once again reviewed the goal and objective suggested for this category. *EP* expressed the point that not all PLWH are able to use public transportation. *CG* talked about the alternative forms of transportation already funded as part of the continuum of care. She suggested a change in wording. Other members came forward with additions and suggestions about the language of both the goal and the objective. After some back and forth, agreement was reached. *Monika* suggested a voice vote, which was unanimous for approval of this goal and objective.

XVIII. Goals and Objectives for Planning Council Support

Monika once again reviewed the goal and objective in this category. *Sam Kaplan* asked about why a three-year plan was being included in the objectives. *Laura Thomas* explained that HRSA was now requiring this as part of comprehensive planning, with a focus on assessing needs of people not in care. It will have to be submitted with the grant application in 2002. The next topic discussed was community forums to obtain consumer input. Multiple amendments, motions, and suggestions were put forth to change the language of an objective about community forums. The purpose of the forums was clarified for members. The only motion that passed was one that added an additional objective to read as follows: **I.)** The Council will actively solicit consumer input on an ongoing basis. A voice vote on the goals and the revised list of objectives was taken, and this passed unanimously.

XIX. Goals and Objectives for Program Support

Monika once again reviewed the goal and objective suggested for this category. *SS* made a motion to accept the language of the goals and objectives as written. A voice vote was taken and the motion was passed.

XX. Overall or System-Wide Goals and Objectives

Monika once again reviewed the goal and objective suggested for this category. *DF* made a motion to add a goal to read: Improve health status of people of color, especially African Americans, living with HIV not in care. He elaborated two objectives in connection with this goal. Suggestions came forward about the wording of these objectives about the African American community. *DF* stated that in the presentations heard by the Council from service providers and researchers, MSM was an under-served population with high rates of infection. This population required more funding while the rate of infection for other segments of the community was significantly lower. At this point discussion was suspended due to reaching 8:00 PM, the agreed time to end the meeting. The Prioritization Organizing Committee would meet and determine when the vote for this category would be completed.

XXI. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

August 13, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P	Y	Y	Y	N	Y	Y	Y		
2. Toni Butler	*TB*										
3. Jeff Byers	*JB*	P	Y	Y	N	Y	N	Y	Y		
4. Bart Casimir	*BC*	P	Y	Y	Y	Y	N	Y	Y		
5. Cecilia Chung	*CC*	P	Y	Y	N	N	Y	Y	Y		
6. Raymond Combs	*RC*	P	Y	Y	N	Y	Y	Y	Y		
7. John Conley	*JC*										
8. Larry Cruz	*LC*	P	Y	Y	N	N	Y	Y	N		
9. Mark Dunlop	*MD*	P	Y	Y	N	Y	N	Y	Y		
10. Gregory Edwards	*GE*										
11. Donald Frazier	*DF*	P	Y	Y	N	Y	N	Y	Y		
12. Catherine Geanuracos	*CG*	P	Y	Y	Y	Y	Y	Y	Y		
13. Fernando Gomez-Benitez	*FGB*	P	Y	Y	N	Y	B	Y	N		
~~14. Gene Gowdey~~	*GG*										
15. Gary Harrell	*GH*	P	Y	Y	N	N	Y	N	Y		
16. Brad Hume	*BH*	P	Y	Y	Y	N	Y	Y	N		
17. Anthony Huynh	*AH*										
18. Sam Kaplan	*SK*	P	Y	Y	N	Y	N	Y	Y		
19. Gene London	*GL*										
20. Carmen Madriz	*CM*	P	Y	Y	N	N	Y	Y	N		
21. Allen Meyer	*AM*										
22. Jim Mitulski	*JM*	P	Y	Y	Y	Y	Y	Y	Y		
23. Gregory Neumark	*GN*										
24. Stephan Oxendine	*SO*										
25. Edward Patterson	*EP*	P	Y	Y	Y	Y	Y	Y	N		
26. Wayne Peace	*WP*	P	N	Y	N	N	Y	Y	Y		
27. Ken Pearce	*KP*	P	Y	Y	N	Y	Y	Y	B		
28. Alissa Riker	*AR*										
29. M.Jay Sanders	*MJS*	P	Y	Y		N	Y	Y	B		
30. Susan Shea	*SS*	P	Y	Y	N	N	Y	N	Y		
31. Janis Takamoto	*JT*	P	Y	Y	N	N	Y	Y	N		
32. Bob Teague	*BT*										
33. Jose Villarce	*JV*	P	Y	Y	N	N	Y	Y	N		
34. Robert Whitford	*RW*										
35. Mary Jane Wood	*MJW*	P	N	Y	N	N	Y	N	Y		
36. Karen Wuopio	*KW*										
			21-2 Housing	23-6 Food	6-16 Question	18-12 SA	17-5-1 SA	20-3 MH	14-7-2 MH		

HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room

August 27, 2001 4:30 PM

AGENDA

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I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes, 7/23 — VOTE**	**4:36 PM**
V.	**General Announcements**	**4:38 PM**
VI.	**Public Comment**	**4:41 PM**
VII.	**Disclosure of Conflicts of Interest**	**4:48 PM**
VIII.	**Reports**	
	• *Discussion of System Wide Goals & Objectives* — **VOTE**	**4:55 PM**
IX.	**Allocations**	
	• *Discussion of Moving Funds Between Service Categories* — **VOTE**	**5:10 PM**
X.	**Break**	**6:00 PM**
XI.	**Allocations - *Continued***	
	• *Discussion of Rollover Funds* — **VOTE**	**6:10 PM**
	• *Discussion of CBC-Minority AIDS Initiative Funds* — **VOTE**	**6:55 PM**
XII.	**New Business**	**7:20 PM**
XIII.	**Adjourn**	**7:30 PM**

Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Wed	9/5	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	9/5	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	9/10	Steering Committee	25 Van Ness, 5th fl. Conf. Rm.	5:30 – 7:00 PM
Thurs	9/20	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	9/24	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	10/3	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	10/3	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:00 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

DRAFT GOALS AND OBJECTIVES FOR 8/27 MEETING

Goal	Objective	What	When	Funding
Maximize access to health and financial benefits for people with HIV/AIDS.	Encourage benefits counseling programs to do outreach and provide services offsite as feasible.	Determine which programs should and could be doing outreach or providing services offsite.	02-03	Existing resources
Improve health status of women and families with HIV	Work with new Title IV program to eliminate gaps in the continuum of care for families with children		02-03	Existing resources
Bring people with HIV who know their status and are not in care into care	Agencies outreach to people with HIV not in care where appropriate and feasible	Determine which services and programs should and could be doing outreach or providing services offsite	02-03	Existing resources
Increase access to client-centered care by expanding integration of services	A. Increase coordination of mental health, primary care, client advocacy, substance abuse, and case management at the program level.	Evaluate ongoing structures for communication between CARE-funded programs in different service categories; standardize, expand, and solidify current practices.	02-03	Rollover funds for planning. Increased funds for implementation
	B. Increase coordination of mental health, primary care, client advocacy, substance abuse, and case management at the administrative level.	Increase and improve communication and collaboration between HIV Health Services, CSAS, and CMHS.	ongoing	Existing resources.
Improve health status of people of color living with HIV not in care	A. Improve outreach to African American men who have sex with men (MSM) and African American women not in care		*02-03*	*CBC: $50K Existing resources*
	B. Increase access to culturally competent services for African American MSM and African American women not in care		*02-03*	*Existing resources*

	rollover funding	for FY 2001-2002	total:	$ 835,000
priority	goal	objective	what	Amount
	Provide health care to: 40% of those PLWH who are not in care by the year 2002-03	A. Identify all PLWH's not in care in the EMA.	Needs Assessment to define and find PLWH "not in care"	see below
	Continue to address lack of cultural sensitivity to women (especially those with children), transgenders, and heterosexuals.	A. Continue to work with consumers to determine the ways that we can make services more sensitive to the needs of all PLWH's.	Assist PLWH Caucus in formulating standards of care for the EMA that reflect sensitivity; determine what cultural sensitivity really is and how to make it part of the contracts.	part of QM budget
	Assure quality of primary care provided to all PLWH's.	A. Assist in implementing a Quality management program through the DPH that assures that Title 1 providers are meeting primary care standards of care.	Work with HIV Health Services to determine best method for assessing quality of care using quality management techniques. Determine appropriate methods to implement quality management in 02-03. Then assist HIV Health Services in implementing quality management	$250,000
	Maintain existing housing stock	C. Maintain quality of existing housing programs	Allocate rollover funds to pay for repairs, goods, and services.	$200,000
	Promote housing stabilization	A. Increase resources available for emergency housing costs such as security deposits, utilities, and back rent, prioritizing people "not in care"	Short term and ongoing funding for emergency financial resources related to housing, including eviction prevention	$100,000
	Promote housing stabilization	B. Increase legal advocacy for eviction prevention.	Short term or ongoing augmentation of legal services contracts to focus on housing issues.	$15,000
	All people with HIV will have adequate food and nutrition to improve health status.	Ensure food services support increased access to care.	Provide food vouchers to agencies to help bring people into care and retain them in care.	$70,000
	People with HIV have adequate transportation to medical and service appointments and programs to increase access to and maintenance in care.	People with HIV can use appropriate transportation to get to and from appointments.	Provide Muni vouchers to low income and disabled PLWH	$25,000
	The Planning Council will conduct its activities efficiently and effectively and fulfill all mandated roles and responsibilities.	C. All Council members are trained in the core competencies identified by HRSA.	The training plan is developed, implemented and revised as needed, with ongoing training for Council members, and all new Council members are oriented and trained within 30 days of their appointment.	$10,000
	The Planning Council will conduct its activities efficiently and effectively and fulfill all mandated roles and responsibilities.	D. The Planning Council completes a comprehensive needs assessment with a focus on people not in care by May 2002	Needs assessment work group and consultant are identified and assessment is designed and completed.	$100,000

priority	goal	objective	what	Amount
	Strengthen the PWA Caucus	A. Provide immediate resources for PWA Caucus to enhance leadership development, etc.	Hire consultant to assess needs of the Caucus and begin the development of leadership skills, etc. Consultant will assist the Caucus in creating a two-year work plan.	$5,000
	Increase access to care by providing consumers with information about the services available.	A. Provide consumers with information on services and programs available.	Reprint updated service resource guide	$10,000
	Improve the mental health and quality of life of uninsured and underinsured PLWH, in order to increase their ability to access medical care.	Respond to increased need for psychiatric crisis and emergency services provided by licensed professionals for PLWH.	Develop intensive case management component of HIV mental health crisis services.	$12,500
	Improve access to substance use treatment to increase access to health care to improve health status and quality of life for uninsured and underinsured PLWH.	C. Assess level of need for substance abuse treatment for HIV+ women with children.	Conduct assessment of need for substance abuse treatment for HIV positive women with children. Coordinate with existing assessments.	$12,500
	All people with HIV will have the day and respite care they need to access health care and other services.	Outreach to 100 families with HIV/AIDS, in collaboration with the new Title IV project, with information about availability of respite child care to increase utilization of respite child care services.	Provide information to CBC-funded and other outreach workers on the availability of childcare services and how to refer families to it.	$5,000
	To create a more truly "Client Centered" system of care.	4. Expand Integrated Services model throughout the system of care, including the development and delivery of multi-lingual services.	Assist HIV Health Services to define what a fully integrated model of care includes.	12,500.00
	To create a more truly "Client Centered" system of care.	3. Expand Integrated Service Category to be sure that programs include substance use and mental health	Request that HHS report to the council on what services need to be included in an ISP in order for it to be truly integrated (one stop shopping)	$12,500

	CBC		total	$ 250,000
priority	goal	objective	what	amount
	Improve access to substance use treatment to increase access to health care to improve health status and quality of life for uninsured and underinsured PLWH.	A. Increase Spanish language capacity in residential and outpatient programs.	Prioritize Spanish-language capability for substance abuse treatment hiring.	$ 200,000
	DRAFT GOAL - not yet approved			
	Improve health status of people of color living with HIV not in care	*A. Improve outreach to African American men who have sex with men (MSM) and African American women not in care*		$ 50,000

	MOVE FUNDING FROM ANOTHER CATEGORY			$1,185,000	
priority	goal	objective	what	amount	from?
0	**Ensure higest quality services for PLWH**	**Continue quality management program**	**Includes quality-related goals and objectives and HRSA-required elements**	**$250,000**	
	To create a more truly "Client Centered" system of care.	3. Expand Integrated Service Category to be sure that programs include substance use and mental health services.	Request that HHS report to the council on what services need to be included in an ISP in order for it to be truly integrated (one stop shopping)	$150,000	$50K each from CM, MH, and SA.
	Maintain and improve current housing stock	A. Ensure existing housing stock is not reduced.	Allocate funds to support existing housing subsidies jeopardized by increases in FMRs and housing costs.	$455,000	
	Promote housing stabilization	A. Increase resources available for emergency housing costs such as security deposits, utilities, and back rent, prioritizing people "not in care"	Short term and ongoing funding for emergency financial resources related to housing, including eviction prevention	$100,000	
	Promote housing stabilization	B. Increase legal advocacy for eviction prevention.	Short term or ongoing augmentation of legal services contracts to focus on housing issues.	$30,000	
	Promote housing stabilization	D. Provide appropriate staffing to respond to the higher level of needs in the harm reduction environment.	Increase case management and clinical support staffing levels in large residential facilities.	$200,000	
	Broaden available housing opportunities	B. Expand number of rooms available for emergency housing	Allocate funding to support expansion of emergency housing program or development of new housing program initiatives.	$250,000	

	increased funding*		plus unfunded items from "move" and "CBC" spreadsheets			
priority	**goal**	**objective**	**what**	**amount**		
	Provide health care to: 40% of those PLWH who are not in care by the year 2002-03	B. Program planning and design.	Analyze results of assessment done 01-02		Increased funding;	
	Provide health care to: 40% of those PLWH who are not in care by the year 2002-04	C. Implement programs to find and keep PLWH's in primary care	RFP's for new programs and increase funding to current providers for capacity building		Increased funding;	CBC dollars
	Evaluate feasibility of fully integrating Complementary Therapy as a health care option in a declining funding situation.	A. Evaluate use of Complementary Therapy as a health care option by the targeted underserved populations of Ryan White.	Determine how many severe need clients are utilizing Complementary Therapy and make recommendations to council for this population. Include this in "not in care" assessment to determine who is using Complementary cares as Primary care and therefore not considered in care.		Increased funding	
	Improve the mental health and quality of life of uninsured and underinsured PLWH, in order to increase their ability to access medical care.	Respond to increased need for psychiatric crisis and emergency services provided by licensed professionals for PLWH.	Develop intensive case management component of HIV mental health crisis services.		Rollover for planning.	Increased funds for implement ation

*These are all items that will be funded if additional Title I funds are received for FY 2002-2003.
Items from other pages that do not get funded will be added to this list.

Approved Goals and Objectives for 2002-03

Existing resources:	to be done within scope of existing programs and resources
Rollover:	during FY 01-02 with rollover or "unfunds" from FY 00-01. Same as "carryforward".
Increased funding:	only if increased Title I funding or funding available from another source (e.g. new grants)
CBC:	to be funded with new CBC/MAI funds, for people of color
Move funds:	move current resources out of existing programs for this
Other funding:	other funding stream identified

OVERALL

Goal	Objectives	What	When	Funding Implication
To create a more truly "Client Centered" system of care.	1. Provide more training to providers working with "severe need" populations on culturally appropriate service delivery models.	1 training on each severe need group: Homeless Substance use Mental Health Women Transgenders Hepatitis C Doubly and triply diagnosed clients.	02 – 03	Other funding: AETC training budget
	2. Include an evaluation of culturally appropriate or sensitive behaviors in the quality management assessment of providers.	Define behaviors that can be measured to indicate adequate competency in severe need populations.	02 – 03	Included in QM budget
	3. Expand Integrated Service Category to be sure that programs include substance use and mental health services.	Request that HHS report to the council on what services need to be included in an ISP in order for it to be truly integrated (one stop shopping)	02 - 03	Rollover: $12.5K for assessment and report. Move funds: $50K each from case management (stand-alone), Mental Health, and substance use. *Use unexpended ISP funds*
	4. Expand Integrated Services model throughout the system of care, including the development and delivery of multi-lingual services.	Assist HIV Health Services to define what a fully integrated model of care includes.	02 - 03	Rollover: $12.5K

HEALTH CARE

Goal	Objectives	What	When	Funding Implication
Goal #1 Provide health care to: 40% of those PLWH who are not in care by the year 2002-03	A. Identify all PLWH's not in care in the EMA.	Needs Assessment to define and find PLWH "not in care"	Before 3.02	See Planning Council Support
	B. Program planning and design.	Analyze results of assessment done 01-02	02-03	Increased funding; Existing resources
	C. Implement programs to find and keep PLWH's in primary care	RFP's for new programs and increase funding to current providers for capacity building	03-04	Increased funding; Existing resources
Goal #2 Provide access and choice in Dental Providers	A. Continue to evaluate effectiveness of new contracts to provide decentralized Dental care.	Evaluation of new decentralized contracts.	02-03	Existing resources
	B. Maximize use of other funding streams for dental care, especially Medi-Cal and TITLE F reimbursement.	Presentation to Council re steps taken to assure maximization of Title F and Medi-cal streams of funding	01-03	Existing resources
Goal #3 Continue to foster collaboration and integration between primary care, substance use and mental health services.	A. Continue to convene the primary care, substance use and, mental health task force to make recommendations about how these groups may more effectively interact.	Report from Task Force with recommendations and action plan.	02-03	Evaluate funding when recommendations available.
	B. Report to Council on recommendations of Task force	Evaluation of recommendations by Evaluation and Implementation Committee	02-03	Funding for 03-04-.
Goal #4 Maximize appropriate social assistance to clients to ensure participation in Primary Care.	A. Complete Case management, peer and treatment advocacy and practical support assessment.	Evaluation of recommendations by Evaluation and Implementation Committee	02-03	Funding for 03-04-.

Goal	Objectives	What	When	Funding Implication
Goal #5 Evaluate feasibility of fully integrating Complementary Therapy as a health care option in a declining funding situation.	A. Evaluate use of Complementary Therapy as a health care option by the targeted underserved populations of Ryan White.	Determine how many severe need clients are utilizing Complementary Therapy and make recommendations to council for this population. Include this in "not in care" assessment to determine who is using Complementary cares as Primary care and therefore not considered in care.	01-03	Increased funding
Goal #6 Continue to address lack of cultural sensitivity to women (especially those with children), transgenders, and heterosexuals.	A. Continue to work with consumers to determine the ways that we can make services more sensitive to the needs of all PLWH's.	Assist PLWH Caucus in formulating standards of care for the EMA that reflect sensitivity; determine what cultural sensitivity really is and how to make it part of the contracts.	01-03	Rollover: $30K
Goal #7 Assure quality of primary care provided to all PLWH's.	A. Assist in implementing a Quality management program through the DPH that assures that Title 1 providers are meeting primary care standards of care.	Work with HIV Health Services to determine best method for assessing quality of care using quality management techniques. Determine appropriate methods to implement quality management in 02-03. Then assist HIV Health Services in implementing quality management programs.	01-03	Rollover: $250k For entire quality management project

Housing

Goal	Objective	What	When	Funding
Maintain and improve current housing stock	A. Ensure existing housing stock is not reduced.	Allocate funds to support existing housing subsidies jeopardized by increases in FMRs and housing costs.	02-03	$455K Move funds OR Other funding
	B. Advocate for increased building code compliance and enforcement by gaining Council seat on the SRO Task Force.	Gain appointment to seated task force for planning council member.	02-03 or sooner	Existing resources
	C. Maintain quality of existing housing programs	Allocate rollover funds to pay for repairs, goods, and services.	01-02 02-03	$200K Rollover Potential rollover request for 02-03
Promote housing stabilization	A. Increase resources available for emergency housing costs such as security deposits, utilities, and back rent, prioritizing people "not in care"	Short term and ongoing funding for emergency financial resources related to housing, including eviction prevention	02-03 and/ or sooner	$100K Rollover $100K Move funds for ongoing program
	B. Increase legal advocacy for eviction prevention.	Short term or ongoing augmentation of legal services contracts to focus on housing issues.	02-03 and/ or sooner	$15K Rollover $30K Move funds Ensure that previous funds have been disbursed.
	C. Ensure all housing assistance programs include a strategy which focuses on shifting clients into or maintaining stable housing.	Continue to use contract language to support program goals of encouraging stable housing.	02-03	Existing resources
	D. Provide appropriate staffing to respond to the higher level of needs in the harm reduction environment.	Increase case management and clinical support staffing levels in large residential facilities.	02-03	200K Move funds for ongoing support.
	E. Educate and train staff who are working with active users.	Provide training to CARE funded providers regarding housing active users; including, training in harm reduction strategies.	02-03	Add to Program Support scope of work. Estimate $10k
Broaden available housing opportunities	A. Increase resources for master leasing of buildings with on-site integrated support services, including medical care.	Allocate funding to support expansion of emergency housing program or development of new	02-03 03-04	Potential rollover in 02-03 for start-up

		housing program initiatives.		Potential need for new funds in 03-04
	B. Expand number of rooms available for emergency housing	Allocate funding to support expansion of emergency housing program or development of new housing program initiatives.	02-03	250K move funds for ongoing support.
	C. Pursue more collaborative housing projects with other funding sources.	Support DPH Housing in leveraging multiple funding sources and collaborations for development of new and ongoing housing program initiatives.	ongoing	Existing resources
	D. Prioritize HOPWA funds for capital projects rather than ongoing support services.	Collaborate with San Francisco Redevelopment Agency and the Mayor's Budget Office to seek replacement funding for support services, in order to free HOPWA funds for development of capital projects.	ongoing	Potential future reallocation of CARE funds and new allocation of non-CARE funds.

Food

Goal	Objective	What	When	Funding
All people with HIV will have adequate food and nutrition to improve health status.	Ensure food services support increased access to care.	Provide food vouchers to agencies to help bring people into care and retain them in care.	02-03	Rollover: $70K

Mental Health

Goal	Objective	What	When	Funding
Improve the mental health and quality of life of uninsured and underinsured PLWH, in order to increase their ability to access medical care.	Respond to increased need for psychiatric crisis and emergency services provided by licensed professionals for PLWH.	Develop intensive case management component of HIV mental health crisis services.	02-03	$12.5K rollover for planning. Increased funds for implementation

Substance Abuse

Goal	Objective	What	When	Funding
Improve access to substance use treatment to increase access to health care to improve health status and quality of life for uninsured and underinsured PLWH.	A. Increase Spanish language capacity in residential and outpatient programs.	Prioritize Spanish-language capability for substance abuse treatment hiring.	02-03	Contract language $200K CBC funding
	B. Increase cultural competency with Latino populations, female clients, and transgender clients in residential and outpatient programs.	Integrate analysis of cultural and linguistic competencies into QM plan. Implement training as indicated by analysis.	02-03	Integrate into QM Plan Training funds from program support.
	C. Assess level of need for substance abuse treatment for HIV+ women with children.	Conduct assessment of need for substance abuse treatment for HIV positive women with children. Coordinate with existing assessments.	02-03	Rollover: $12.5K

Client Advocacy

Goal	Objective	Activity	Time	Funding
Increase access to care for PLWH through client advocacy.	Ensure clients are receiving benefits screenings and increased benefits when eligible.	Evaluate ongoing efforts to increase benefit screenings through contract monitoring.	02-03	Existing resources
	[see legal advocacy objective under housing]			

Case Management

Goal	Objective	What	When	Funding
Increase access to care for PLWH through coordinated and integrated case management.	A. Increase integrated case management services and peer and treatment advocacy for people of color	Use CBC funding to increase service capacity at people of color community based agencies.	02-03	Existing resources
Ensure case management services are cost effective and high quality	A. Monitor duplication of case management services to ensure cost-effective use of resources.	Utilize Reggie data, networking mechanisms and practices among providers, and AIDS office monitoring programs to monitor case management duplication.	ongoing	In QM project.
	B. Develop standards of care for peer advocacy	Follow recommendations from CM/PA/TA report.	01-02	In QM program.
	C. Develop standards of care for treatment advocacy	Follow recommendations from CM/PA/TA report	01-02	In QM program.
	D. Evaluate ISP Model	Develop standards for composition of ISPs, evaluate effectiveness, consistency, and efficiency of service delivery comparing integrated and stand-alone models.	02-03	In QM program.
	E. Support implementation of standards of care when completed for Peer Advocacy, Treatment Advocacy, CM Coordination.	Disseminate, train on, and evaluate adherence to standards of care when completed.	02-03	In QM program.

Day & Respite Care

Goal	Objective	Activity	Time	Funding
All people with HIV will have the day and respite care they need to access health care and other services.	Outreach to 100 families with HIV/AIDS, in collaboration with the new Title IV project, with information about availability of respite child care to increase utilization of respite child care services	Provide information to CBC-funded and other outreach workers on the availability of childcare services and how to refer families to it.	**02-03**	Rollover: $5K Existing resources

Transportation

Goal	Objective	Activity	Time	Funding
People with HIV have adequate transportation to medical and service appointments and programs to increase access to and maintenance in care.	People with HIV can use appropriate transportation to get to and from appointments.	Provide Muni vouchers to low income and disabled PLWH	**02-03**	Rollover: $25K

Planning Council Support

Goal	Objective	Activity	Time	Funding
The Planning Council will conduct its activities efficiently and effectively and fulfill all mandated roles and responsibilities.	A. The Planning Council conducts monthly Council and committee meetings		**02-03**	Existing resources

	B. The Planning Council meets membership requirements and expectations.	Membership Committee assesses membership needs, and recruits, selects, and nominates new members.	**02-03**	Existing resources
	C. All Council members are trained in the core competencies identified by HRSA.	The training plan is developed, implemented and revised as needed, with ongoing training for Council members, and all new Council members are oriented and trained within 30 days of their appointment.	**01-02** **02-03**	Rollover: $10K Existing resources
	D. The Planning Council completes a comprehensive needs assessment with a focus on people not in care by May 2002	Needs assessment work group and consultant are identified and assessment is designed and completed.	**01-02** **02-03**	Rollover: $100K
	E. The Planning Council completes its 3-year plan by September 2002.	Planning work group and consultant are identified and plan is developed in compliance with HRSA expectations.	**02-03**	Existing resources
	F. The Planning Council leadership and staff complete all relevant Conditions of Award in a timely manner.	Co-chairs and staff write and sign letters and produce other documentation for HRSA as needed.	**02-03**	Existing resources
	G. Increase effectiveness of Planning Council support	Investigate other models of support and assess current support structure and revise as needed.	01-02	Existing resources

	H. Council staff fulfills all HRSA requirements and expectations as well as those defined by the Council.	The Council support staff produces timely and accurate minutes of all Council and committee meetings, and the Council meets all open meeting and notification requirements including timely posting of notices and minutes on the internet.		Existing resources
	I. The Council will actively solicit consumer input on an ongoing basis.			Existing resources
Strengthen the PWA Caucus	A. Provide immediate resources for PWA Caucus to enhance leadership development, etc.	Hire consultant to assess needs of the Caucus and begin the development of leadership skills, etc. Consultant will assist the Caucus in creating a two-year work plan.	Project to be completed by 2/02	Rollover: $5K
	B. Increase Council Support budget to include a budget line item for activities that support the PWA Caucus such as mentoring, facilitation, leadership development, etc.	Ongoing support for the continued development of mentoring, leadership, facilitation skills, etc. Evaluate progress on 2-year plan.	02 – 03	Existing resources: $10K in Council Support Budget
	C. The PWA Caucus will work in collaboration with the Membership Committee to advise the Council on the issue regarding the "outreach" line item in the Council Support budget.	In collaboration with the Membership Committee, evaluate the most effective use of outreach dollars. Create outreach plan.	01 – 02	Existing resources: $7,350 Council Support Budget

Program Support

Goal	Objective	What	When	Funding
CARE-funded providers receive the technical assistance needed to ensure the quality and effectiveness of the care and services provided to people with HIV/AIDS.	A. Prioritize training and technical assistance on quality management to health care providers in conjunction with quality management program.	Provide training to providers as needed on development and implementation of quality management	**02-03**	In quality management budget
	B. Increase ability to serve multiply diagnosed people with HIV.	Provide training to providers on working effectively with multi-diagnosed clients.	**02-03**	Existing resources
Increase access to care by providing consumers with information about the services available.	A. Provide consumers with information on services and programs available.	Reprint updated service resource guide	01-02	Rollover: $10K

Running totals

Rollover: $835K
Move funds: $1.185K+
CBC:$250K
Increased:

MEMO

DATE: August 20, 2001
TO: Planning Council Members
FROM: Laura Thomas
HIV Health Services
RE: CARE Title I Application

I am working on the CARE Title I application. This is the document we submit to HRSA every year to justify receiving Title I funds. It is also part of the competitive process for CARE dollars, and the better an application we submit, the more funding we may receive. One of the sections describes the Planning Council and documents the fact that the membership reflects the demographics of the epidemic. To fill out that section, I need each Council member to fill out the attached form.

Please fill out both sides of the form, and for the section entitled "Principal Areas of Interest/Expertise" please **number** your top three areas of expertise; if you just check them off, I will use my editorial discretion to assign you numbers. Please mail or fax it back to me, or bring it to the August 27th meeting. My fax number is: 415/431-7547. I use the information on the form to document the extent to which the Council is representative of and reflective of the HIV/AIDS epidemic in the EMA.

If you have any questions about the form, please contact me by phone (554-9169) or email. Thanks for your help with this.

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HIV HEALTH SERVICES PLANNING COUNCIL

REPRESENTATION INFORMATION FOR THE FY 2002 GRANT APPLICATION

Name: _____

Title: _____

Agency or affiliation: _____

Category of representation (check ALL that apply):

_____ Health care provider, including federally qualified health centers
_____ Community-based organization/AIDS service organization
_____ Social service provider
_____ Housing or homeless services provider
_____ Mental health provider
_____ Substance abuse provider
_____ Local public health agency
_____ Hospital planning agency or health care planning agency
_____ Affected communities, including individuals with HIV/AIDS and historically underserved groups and subpopulations
_____ Non-elected community leader
_____ State Medicaid agency
_____ State Title II agency
_____ Title IV grantee, or representative of an organization serving children, youth, and families with HIV
_____ Title III grantee
_____ Grantee of other Federal HIV programs (e.g. AETC, Dental Reimbursement, SPNS, HOPWA. SAMHSA)
_____ HIV prevention provider
_____ Formerly incarcerated PLWH or a representative of incarcerated PLWH

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Demographics (please circle responses)

Gender:	male	female	transgender	
HIV status:	HIV+	HIV-	don't know	decline to state

Sexual orientation: gay lesbian bisexual
heterosexual other decline to state

Race/ethnicity: White African American Native American
Latino Asian/Pacific Islander Other_____

CARE Consumer Status (check all that apply):

_____ Current consumer of CARE-funded services
_____ Past consumer of CARE-funded services
_____ Not a consumer/not eligible for services

Principal Areas of Interest/Expertise:

Please number your top three areas of interest or expertise as 1, 2 and 3:

_____ Health needs of men of color who have sex with men
_____ Health needs of white men who have sex with men
_____ Women's HIV health needs
_____ Children's HIV health needs
_____ Youth's HIV health needs
_____ General public health
_____ Substance use/abuse services, including IDU health needs
_____ Mental health services
_____ Other non-medical support services (e.g. housing, case management, etc.)
_____ Evaluation
_____ Health planning
_____ Primary care: outpatient/ambulatory care
_____ Primary care: anti-retroviral therapies
_____ Other: _____

Check here if you are a representative of or an advocate for these communities or groups:

_____ homeless/marginally housed
_____ immigrants
_____ transgender
_____ families and children
_____ multiply-diagnosed
_____ incarcerated/recently released
_____ youth
_____ monolingual Spanish speakers

Please return to Laura Thomas, AIDS Office by August 27, 2001

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Handout 2

(Prepared by Caitlyn Ryan for John Snow Inc. as part of the Ryan White Technical Assistance Contract.)

Parliamentary Procedures At A Glance

To Do This	You Say This	May You Interrupt the Speaker?	Must You be Seconded?	Is the Motion Debatable	Can the Motion be Amended?	What Vote is Needed?
Adjourn the meeting	"I move to adjourn."	no	yes	no	no	majority
Recess the meeting	"I move that we recess until..."	no	yes	no	yes	majority
Complain about noise, room temperature, etc.	"Point of privilege."	yes	no	no	no	no
Suspend further consideration of something	"I move we table it."	yes	yes	no	no	majority
End debate	"I move the previous question."	no	yes	yes	yes	2/3 vote
Postpone consideration of something	"I move we postpone this matter until..."	no	yes	yes	yes	2/3 vote
Have something studied further	"I move we refer this matter to a committee."	no	yes	yes	yes	majority
Amend a Motion	"I move that this motion be amended by..."	no	yes	yes	yes	majority
Introduce business (or make a primary motion)	"I move that..."	no	yes	yes	yes	majority
Object to a procedure or to a personal affront	"Point of order."	yes	no	no	no	chair decides
Request information	"Point of information."	if urgent	no	no	no	none
Ask for vote by actual count to verify a voice vote	"I call for a division of the house."	no	no	no	no	none
Object to considering something undiplomatic or improper	"I object to consideration of the question."	yes	no	no	no	2/3 vote
Take up a matter previously tabled	"I move we take from the table..."	no	yes	no	no	majority
Reconsider something already disposed of	"I move we now reconsider our action relative to..."	yes	yes	yes	no	majority
Consider something out of the scheduled order	"I move that we suspend the rules and consider..."	no	yes	no	no	2/3 vote
Vote on a ruling by the Chair	"I appeal the chair's decision."	yes	yes	yes	no	majority

Activity 6

MEETINGS BY THE "RULES": A GUIDE TO PARLIAMENTARY PROCEDURE

Formal meetings, such as the Ryan White CARE Act planning body meetings, are usually organized by a set of procedures called Robert's Rules of Order. These "rules" establish the ways that things get accomplished at meetings. They ensure that meetings are conducted in an organized way.

Robert's Rules of Order are based on three important principles, or "rights":

- the right of the majority to rule
- the right of the minority to be heard, and
- the right of the individual to have a voice in the decision-making process

Robert's Rules of Order are sometimes referred to as *parliamentary procedure.*[3] Under this system, business is conducted by acting on motions—ideas or actions that committee members suggest.

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IN THEIR OWN WORDS...

"The structure of the meeting can make it hard to keep consumers involved."

[3] In this section we explain the process by which planning groups make decisions using Roberts Rules of Order. We decided to use a light-hearted example – serving ice cream and cake at meetings – because we wanted to emphasize the **process** of making motions and amendments, rather than the content of the subject under discussion.

This is what happens:

A member of the planning group introduces a main **motion.**

- *"I move that we have ice cream and cake at all meetings."*

Another member then **seconds the motion** (supports it).

- *"I second the motion."*

The person in charge of the meeting then **restates the motion.**

- *"It has been moved that ice cream and cake be served at meetings."*

And opens the meeting to **discussion** about the motion.

- *"Is there any discussion?"*

Discussion takes place.

- *"I think it is a really good idea. I'm always hungry when I come to these meetings, and it would be great to have ice cream and cake to look forward to."*
- *"I'm not so sure about this. Ice cream and cake are not healthy foods. I think we should have carrot sticks instead."*
- *"I'm in favor of the motion. These meetings are so long. It would be great to have a break and have ice cream and cake at each one."*

After a while, when discussion is finished, or when it is time to stop the discussion, the person in charge of the meeting asks if participants are ready to **vote** on the motion. If there is general agreement (consensus), the person in charge restates the motion and takes a vote.

- *"All those in favor of the motion?"* (People can vote with their voices or by raising their hands.)
- *"All those opposed?"* (Again, people can vote verbally or by raising their hands.)

In the case of the ice cream and cake motion, all the members of the committee voted "Aye!" They were in favor of the motion and it passed unanimously! In the future, ice cream and cake will be served at meetings.

Sometimes, though, the process is not so simple. For example:

During discussion one committee member was concerned about the expense of having refreshments served at meetings.

- *"I don't think our committee can afford to have ice cream and cake at every meeting. I would like to amend the motion to have ice cream and cake at every other meeting."*

There are various rules about whether the original motion can be **amended** (changed).

- Sometimes the person who made the original motion is asked to accept a **friendly amendment.** In this case, to change the wording of the original motion to have ice cream and cake at every other meeting.
- In more formal meetings, the person in charge may ask that the original motion be withdrawn, and then restated to include the proposed changes.
- Or the person in charge may require that the original motion be voted on. If it is defeated, a new motion, which includes the proposed changes, can then be introduced.

In our example, the **friendly amendment** was not accepted. The original motion was put to a vote, and it passed. Ice cream and cake will be served at all meetings!

Here's another example:

There were many concerns about the cost of ice cream and cake at committee meetings. Discussion continued. Finally, someone suggested that the matter be **referred to a sub-committee.**

- *"We have so many questions about this issue. I propose that we refer the motion to a sub-committee to find out exactly what it will cost."*

If there is general agreement, the person in charge of the meeting refers the motion to a subcommittee.

- *"Please gather the necessary information and report back to the full committee at next month's meeting."*

And one more example:

Discussion about ice cream and cake dragged on and on and on. Some people were concerned about the cost; others worried about the nutritional value. Many, however, thought it was a splendid idea. No one could agree. After quite a long time, someone acts to end the discussion and require the members to vote on the **motion** to have ice cream and cake at all meetings.

- *"I move the previous question."* (make a motion to end discussion and take a vote)

Someone else supports the idea to end discussion.

- *"I second the motion."*

The person in charge then asks for a vote. Two-thirds of the people vote to end the discussion. They then take a vote on the original motion. And, finally, it is agreed that ice cream and cake will be served at all meetings!

Remember, Robert's Rules of Order are intended to provide a fair decision-making strueture. They are not meant to stop important discussions or to take up lots of valuable time. They are meant to help groups work toward eonsensus in the fairest and most efficient way possible. **Table 7** presents the terms you are most likely to hear during meetings. Keep it as a handy referenee on parliamentary proecdure.

Table 7
Robert's Rules of Order: A Glossary of Terms

Motion — an idea or action that a planning body member suggests or recommends

Second the motion — support a suggestion or recommendation that has been made

Amend the motion — offer a change or addition to a motion

Amendment — a proposed change to a motion

Refer the motion — ask a subcommittee to gather additional information about a motion

Postpone the motion — delay a motion until a stated future time

Move the question — bring an end to discussion and take a vote on the motion

Point of order — suggest that a "rule" of parliamentary procedure has been broken

WHO IS ROBERT?

Henry Martyn Robert was an officer in the United States Army. One day, without any warning, he was asked to run a meeting at his church. It was a disaster! People wouldn't listen to each other; they wouldn't take turns speaking. He was very embarrassed, and he vowed never to attend another meeting until he understood proper meeting procedures. He studied many books on British parliamentary procedure and in 1876 published the first edition of *Robert's Rules of Order*.

Adapted in part from *10 Minutes to Better Board Meetings* by Norah Holmgren (1997), Planned Parenthood Federation of America

02

24/01

HIV Health Services Planning Council

City Hall, Room 201 1 Dr. Carlton B. Goodlett Place

September 24, 2001 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:33 PM**
III.	**Review and Approval of Agenda**	**4:36 PM**
IV.	**Review and Approval of Minutes, 7/23 — VOTE**	**4:39 PM**
V.	**General Announcements**	**4:43 PM**
VI.	**Public Comment**	**4:48 PM**
VII.	**Reports**	
	• *Department of Public Health, HIV Health Services*	**4:55 PM**
	- Michelle Long Dixon	
	• *Budget to be included in Grant Application for FY02-03* — **VOTE**	**5:15 PM**
	- Laura Thomas	
	• *Membership Committee*	**5:35 PM**
	- Slate of Nominations — **VOTE**	
VIII.	**Break**	**6:00 PM**
	• *Feedback on Prioritization Process*	**6:15 PM**
	- Suggestions for Improvement from Council Membership	
IX.	**New Business**	**7:20 PM**
X.	**Adjourn**	**7:30 PM**

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already posted

Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Wed	10/3	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	10/3	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	10/8	Holiday		
Thurs	10/18	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	10/22	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	11/7	Housing Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Wed	11/7	PWA Caucus	25 Van Ness, Room 330	4:30 – 7:30 PM
Thurs	11/15	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	11/26	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-1 ine to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

HIV Health Services Planning Council

City Hall, Room 201 1 Dr. Carlton B. Goodlett Place

October 22, 2001 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:33 PM**
III.	**Review and Approval of Agenda**	**4:36 PM**
IV.	**Review and Approval of Minutes,** 7/30 and 8/13 — **VOTE**	**4:39 PM**
V.	**General Announcements**	**4:43 PM**
VI.	**Public Comment**	**4:48 PM**
VII.	**Reports**	
	• *Membership Committee*	**4:55 PM**
	• *Housing Committee*	**5:10 PM**
	• *PWA Caucus*	**5:25 PM**
	• *Implementation & Evaluation Comm.*	**5:45 PM**
VIII.	**Break**	**6:00 PM**
	• *Steering Committee*	**6:15 PM**
	- Co-Chair Elections — **VOTE**	
	- Committee Structure/New or Ad-hoc Committees	
	- Clarify Meeting Schedule	
IX.	**New Business**	**7:15 PM**
X.	**Adjourn**	**7:30 PM**

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
Mon	11/5	Implementation & Evaluation Comm.	25 Van Ness, Room 330	5:30 – 7:00 PM
Wed	11/7	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	11/7	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	11/12	Holiday		
Thurs	11/15	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	11/26	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	12/3		25 Van Ness, Room 330	4:30 – 7:30 PM
Wed	12/5	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	12/5	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM

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HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

(22)

August 13, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P	Y	Y	Y	N	Y	Y	Y		
2. Toni Butler	*TB*										
3. Jeff Byers	*JB*	P	Y	Y	N	Y	N	Y	Y		
4. Bart Casimir	*BC*	P	Y	Y	Y	Y	N	Y	Y		
5. Cecilia Chung	*CC*	P	Y	Y	N	N	Y	Y	Y		
6. Raymond Combs	*RC*	P	Y	Y	N	Y	Y	Y	Y		
7. John Conley	*JC*										
8. Larry Cruz	*LC*	P	Y	Y	N	N	Y	Y	N		
9. Mark Dunlop	*MD*	P	Y	Y	N	Y	N	Y	Y		
10. Gregory Edwards	*GE*										
11. Donald Frazier	*DF*	P	Y	Y	N	N	N	Y	Y		
12. Catherine Geanuracos	*CG*	P	Y	Y	Y	Y	Y	Y	Y		
13. Fernando Gomez-Benitez	*FGB*	P	Y	Y	N	Y	B	Y	N		
~~14. Gene Gowdey~~	*GG*										
15. Gary Harrell	*GH*	P	Y	Y	N	N	Y	N	Y		
16. Brad Hume	*BH*	P	Y	Y	Y	N	Y	Y	N		
17. Anthony Huynh	*AH*										
18. Sam Kaplan	*SK*	P	Y	Y	N	Y	N	Y	Y		
19. Gene London	*GL*										
20. Carmen Madriz	*CM*	P	Y	Y	N	N	Y	Y	N		
21. Allen Meyer	*AM*										
22. Jim Mitulski	*JM*	P	Y	Y	Y	Y	Y	Y	Y		
23. Gregory Neumark	*GN*										
24. Stephan Oxendine	*SO*										
25. Edward Patterson	*EP*	P	Y	Y	Y	Y	Y	Y	N		
26. Wayne Peace	*WP*	P	N	Y	N	N	Y	Y	Y		
27. Ken Pearce	*KP*	P	Y	Y	N	Y	Y	Y	B		
28. Alissa Riker	*AR*										
29. M.Jay Sanders	*MJS*	P	Y	Y		N	Y	Y	B		
30. Susan Shea	*SS*	P	Y	Y	N	N	Y	N	Y		
31. Janis Takamoto	*JT*	P	Y	Y	N	N	Y	Y	N		
32. Bob Teague	*BT*										
33. Jose Villarce	*JV*	P	Y	Y	N	N	Y	Y	N		
34. Robert Whitford	*RW*										
35. Mary Jane Wood	*MJW*	P	N	Y	N	N	Y	N	Y		
36. Karen Wuopio	*KW*										
			21-2 Housing	23-0 Food	6-16 Question	10-12 SA	17-5-1 SA	20-3 MH	14-7-2 MH		

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PWA CAUCUS MEETING

Meeting Date:	October 3, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:30 PM
Members Present:	Gary Harrell (Co-Chair) and Brad Hume
Others Present:	Richard Bargetto (HIV Consumer Rights Advocate); Felicia Elizondo and Charles Siron (Nominees to Council); Ed Bedard, John Claude Koury and Eric Whitney, Consumers; and Jeffrey Harding (Minutes)
Next Meeting:	Wednesday, November 7, 2001, 25 Van Ness, Room 330-B, 5:30-7:30 PM

I. Introductions

II. Agenda

Consumer Rights Advocacy Project Report; Housing Wait List; Leadership Training and Election; Unfunds or Rollover.

III. Consumer Rights Advocacy Project Report

Richard Bargetto reviewed new cases for the month of September 2001. There were three grievances against AHP. Clients did not want to share Reggie information with the Foundation and/or Shanti when intake is performed at AHP. AHP will be re-evaluating this issue and will put sensitive information into notes not available to other agencies and a procedural change will be implemented where intake worker, not therapist, will be performing intake. Larger Reggie issues were discussed. There were two grievances against the HWL. Administration of the HWL has been turned over to DPH, and clients were given information about the change and the chance to provide new data. It is up to the Client to keep the HWL updated on personal information. The next client was discontinued service from Project Open Hand. Client will receive services through a surrogate shopper. The next clients were denied services from SFAF because there was conflicting information about their HIV status. Further investigation in needed. Next client claimed the staff of SFAF treated him poorly. The next client had an issue with an employee distributing medication at Derek Silva residence, and is awaiting response. Next two clients have grievances with ALRP and matters are pending. *See Attachment A.*

IV. Housing Wait List

DPH has been re-evaluating the Housing Wait List. Position on the HWL does change depending on the type of housing requested and/or the placement of others from the list. It is the client's responsibility to keep HWL informed of changes in personal information. *John Claude Koury* is investigating volunteering. *Brad Hume* is trying to get someone to provide additional written information. *Eric Whitney* expressed concern that clients do not know how or where to update information. In addition, why or why not is Reggie being used as a source of client information?

V. Unfunds Proposal / Leadership Training

BH presented a springboard proposal to use the allocation of rollover funding approved recently by the Council to provide immediate resources to PWA Caucus for leadership development. The question was raised as to whether Co-chairs of the Caucus must be Council Members. *Brad Hume* proposed that the Co-chair vote be postponed until the next month. *Richard Bargetto* proposed the money ($5,000) be spent on a Leadership Person to run meetings. *Eric Whitney* agreed to create a proposal to outline the Leadership Person's role and create a scope of work through e-mail correspondence with other committee members.

VI. Membership Caucus Collaboration

VII. Public Comment

No Public Comment was presented.

VIII. Adjournment

HIV CONSUMER RIGHTS ADVOCACY PROJECT
1540 Market Street, Suite 301
San Francisco, CA 94102
Tel: 415.863.8131
Fax: 415.863.0831

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PWA CAUCUS – SEPTEMBER 2001 REPORT

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LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Dental	UOP	Quality of Care	Resolved
2-	Case Mngt	Positive Resource Center	Alleged Professional Negligence	Pending
3-	Housing	Dept. Public Health/HWL	Confusion with HWL	Pending
4-	Housing	Peter Claver	Building Cleanliness	Pending
5-	Mental Health	Center for Special Problems	Scheduling	Withdrawn
6-	Housing	Derek Silva	Quality of Services	Resolved
7-	Legal	ALRP	Quality of Services	Pending
8-	Primary Med	St Mary's	Quality of Services	Pending

1- Client claims that he not only received unsatisfactory services from UOP dental clinic, but also that after one year his dental needs have not been fully addressed. The client filed a grievance in the form of a memo addressed to the Advocacy Project, which was forwarded to UOP. UOP referred this memo to their attorney, and responded to the client's memo with a dismissal from the UOP program and a referral to Community Dental. UOP's attorney asserts that the memo was not a grievance, and insists that UOP has no further obligations to the client. The client, an attorney, wishes to prepare his own response to UOP's attorney, and the Advocacy Project is advising on the process. Advocacy Project met with DPH who will be conducting an investigation into these allegations as well as other allegations of false billings by UOP to DPH. Client is satisfied with the direction of his case and all parties are scheduled to meet to address any final claims.

2- Client claims that he received incorrect advice from a benefits counselor. As a result of this alleged incorrect information, client claims that he did not have insurance coverage during a month when he incurred services. Now the client has a medical insurance bill for $1,200. Client filed a grievance with PRC claiming professional negligence. After an investigation, PRC responded that the benefits counselor does not recall the events as the client had stated. PRC agreed to include the critical information in the next in-service training and offered to assist the client to pay off his medical bills with a payment plan. Client is dissatisfied with the response and has appealed to members of the Board of Directors.

3- Client claims he signed up with the Housing WaitList (Chips) in 1992 and then moved into Derek Silva in 1994. In 1994, while in a deteriorated condition, he claims that he received a phone call for a housing subsidy. Because of his condition, he declined the subsidy. Now, client would like the subsidy based on the theory that his residency at Derek Silva was temporary and he is now in a

condition to accept his subsidy that was offered to him many years ago. Advocacy Project has contacted HWL for documents and will review the hard copy of these documents.

4- Client claims that another resident is urinating outside of his door. He has complained on numer occasions over the past few months and feels that the staff is not responding properly. While the st did agree that the problem did exist at one time, the staff believes that the problem is resolved. Wh the incident happens again, client has been instructed to fill out a work order to clean the area. Advocacy Project reviewed the premises along with other outside authorities and could not identify any unusual odors. Client believes the problem has been improved and is satisfied with the outcom

5- Client wanted to do an in-take at Center for Special Problems (CSP) outside of the normal in-take times. CSP said no and client called the Advocacy Project. CSP contends that no client is unique and must conform to their intake schedule; however, they are also reevaluating whether they can perform the in-take at another time. Grievance has been withdrawn through client inaction.

6- Client claims that his partner committed suicide because no one checked on him after numerous requests for intervention. With the assistance of the Advocacy Project, Client filed a grievance. Th client was initially dissatisfied with the response that he received from Derek Silva. However, once was determined that Derek Silva does have a policy in place for checking on residents and this resident was in fact checked on, the client does not wish to pursue the grievance further. Client is satisfied with the outcome.

7- Client had recent bad experiences with the ALRP in regards to ineffective advocacy, unprofessional conduct. With the assistance of the Advocacy Project, Client filed a grievance with six specific allegations about the poor services he received. The ALRP responded and the client is not satisfie with a majority of the response. With the assistance of the Advocacy Project, client will appeal to Board of Directors.

8- Client claims the services at St. Mary's have greatly deteriorated over the past five years. Specifically, client had to wait for services, high turnover of staff, etc. Also, after client was referred to the Pain Clinic, he allegedly threatened the provider and was discharged from the program. Additionally, because of his dismissal from the pain clinic, he was also dismissed from the Health Center at St. Mary's. Advocacy Project has contacted St. Mary's to determine the circumstances around the dismissal and assisted client in locating new health care.

NEW CASES

	Service	Agency	Issue	Outcome
1-	Mental Health	AHP	Reggie	Pending
2-	Mental Health	AHP	Reggie	Resolved
3-	Mental Health	AHP	Reggie	Resolved
4-	Housing	HWL	Management of List	Resolved
5-	Housing	HWL	Management of List	Pending
6-	Food	Open Hand	Re-instituting services	Pending
7-	Case Management	SFAF	Quality of services	Pending
8-	Case Management	SFAF	Quality of services	Pending
9-	Case Management	SFAF	Quality of services	Pending

10-	Case Management	Derek Silva	Unauthorized Services	Pending
11-	Legal	ALRP	No services	Resolved
12-	Legal	ALRP	No services	Pending

1- Client sought services from AHP. During his intake client was informed that the information would be shared with two other agencies, Shanti and SFAF. Client did not want his personal information shared, thus, the intake processs concluded because AHP could not proceed with the intake without disclosing the information to the other two agencies. Clients contacted the Advocacy Project who has assisted the client in filing a grievance on how clients can access mental health services from AHP with have the information shared with the other two agencies in the HIV Services Partnership.

2- Client wished to receive mental health services from AHP. At the end of his in-take, client was asked to sign a consent to share reggie form. Client did not want his information shared with other agencies. His intake worker, a new intern, then sought information from a staff support person about how to handle the situation. The staff person told the client that he must sign the form and did not inform the client about the non-share option. After the interaction dissolved, the client departed and contacted the Advocacy Project who contacted the Client Services Coordinator. The Coordinator is meeting with the client and will fully explain all the options to him. The client will still seek services from AHP; however, he is not satisfied with the outcome that he still must share his information with two other agencies in the HIV Services Partnership (SFAF & Shanti) in order to receive services.

3- Client sought was seeking mental health services from AHP. During his intake, he signed both a consent to share reggie form and a HIV Services Partnership form. His in-take included information about personal life, including his living situation. Upon his annual review from the SFAF Subsidy program, it was revealed that the client was living in apartment with his partner. When confronted, the client admitted to his partner's domicile status. The foundation threatened litigation for fraud and termination from the subsidy program. Client contacted the Advocacy Project for assistance. Advocacy Project met with the Clinical Services Coordinator at AHP where it was agreed that much of the information that was shared in the HIV Services Partnership should have been more appropriately placed in therapy notes section and therefore not shared with SFAF. This sensitive information was moved. Advocacy Project contacted the SFAF and they will not pursue any fraud claims against client as the client is withdrawing from the subsidy program. Client is not satisfied with the outcome, but he feels he is able to move on from the incident.

4- Client has been on the HWL for numerous years and was told that his number was 51 in January 2001. According to the client, since that time he has only slide further down the list. Client's landlord has only been receiving 30% of client's income in hopes that the subsidy would be arriving very soon. After nines months of waiting, the landlord has served client with 3-day notice to evict. Advocacy Project contacted the HWL to verify client's status. The client is an active member on the list and his position has not moved because some information was not provided by the SFAF to HWL. Client is in the process of now providing the information. Advocacy Project also wrote a letter to landlord to delay any pending eviction proceedings especially in light of the fact that the client will move out at the end of the year. Client is satisfied with the outcome.

5- Client is concerned about how the HWL is being managed. Specifically, why a letter of diagnosis is necessary by the DPH when the reggie system could provide this information. The client's second concern is the list's request for income verification which can vary widely in one year for a client depending on their health status. The Advocacy Project has contacted the HWL and inquired into these questions on behalf of the client. The HWL's response was that the HIV information was not

always provided for even if the client was registered in the reggie system. Additionally, the income information was static and could overlook a person for a program if he/she was otherwise eligible. However, this income information could be changed at anytime by the client calling the HWL to updating their records. Client is not satisfied and is considering an appeal.

6- Client was forbidden to enter the premises on Project Open Hand for three years due to his hostile and abusive conduct and was denied services from the collaboration for one year. Now that year is complete and the suspension of services from the HIV Services Partnership has been removed, client would like to begin receiving groceries from Open Hand. Advocacy Project has contacted Project Open Hand and it is considering a surrogate shopper for the client so that it's safety needs are carefully balanced with the client's need for food. Advocacy Project is assisting client in documenting his good faith effort to minimize future incidents by enrolling in anger management classes.

7- Client claims that when he and his partner were in Los Angeles they called the SFAF for assistance. When they arrived at the SFAF the client claims he was not treated with compassion. When he did receive a hotel voucher to the New Pacific Hotel he encountered prostitution & johns, bloody syringes in the bathrooms and their door was kicked in by another guest. When he returned to the SFAF and complained about the health risks at this hotel, they were then given an voucher to the El Hotel which they believe was not an improvement and contained urination & defacation in elevator and unclean and damaged room. Client has stopped taking his medication to protest the conditions of these hotels. Advocacy Project referred to AEF to find another hotel. Client is satisfied with this temporary measure.

8- Client claims that he has been positive for seven years and has some documentation which tends to suggest that he is HIV positive and went to the SFAF seeking services. The SFAF denied service until results from a local testing center could be established or an out-of-state verification could be confirmed. The client's own records seem to indicate that the client is positive from collateral documentation (copies of prescriptions, tuberculosis forms, diagnosis form from APLA); however th results from a test at the Health Center #1 stated that he was HIV negative. Advocacy Project has contacted APLA and client's doctor in Florida to request further documentation as well as referred client to an additional local clinic for re-testing.

9- Client went to the SFAF seeking services for counseling on going back to work and disability. Client claims that he was treated poorly by staff for merely being "edgy and nervous" which he claims was not allowable conduct. With the help of the Advocacy Project, client wrote a grievance about his experiences and is awaiting a response. The Advocacy Project is monitoring the grievance.

10- Client claims that a case manager at Derek Silva distributed to his partner his psych meds. The client claims that case manager and the resident agreed these meds would be safer if placed in the case manager's office. The client claims that once a week, the resident would have to ask the case manager for his meds and they would eventually be given out by her. Advocacy Project has assisted the client in filing a grievance asking that a policy be put in place so that case managers are not distributing medications. Advocacy Project is monitoring the grievance.

11- Client claims that he is living in substandard housing. He contacted the ALRP to write a letter on his behalf to his landlord to fix some of the problems. The letter has not yet been written and the client contacted the Advocacy Project for assistance. Advocacy Project contacted the ALRP who believ the client would write the letter. After the discussion, ALRP agreed to write the letter on the client's behalf. Client is satisfied with the outcome.

12- Client contacted the ALRP for many issues regarding his housing. Client claims that because of their inaction, the landlord has notified HOPWA about some of the client's violations. Client claims that if ALRP had been involved, he would not be threatened with losing his HOPWA certificate. Advocacy Project has contacted ALRP for further information.

Referral Calls:	HIV Resource Guide Books	2
	HWL Service	1
	Depart. Of Rehab Grievance Proc.	1
	Small Claims Court	3
	Total	6

* Duplicated Client

(Report prepared by Richard Bargetto on 9/30/01)

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HOUSING COMMITTEE

Meeting Date: October 3, 2001

Meeting Place: 25 Van Ness Avenue, Room 330-A

Members Present: Brad Hume (Chair), Catherine Geanuracos, Fernando Gomez-Benitez, and Kevin Johnson

Others Present: Laura Thomas (DPH); Amy Cunninghis (SF AIDS Foundation); Pam Sims and Elizabeth Colomello (SF Redevelopment Agency); Rodney Murphy (Catholic Charities); Steven Feeback, and Jeffrey Harding (minutes).

Next Meeting: Wednesday, November 7, 2001, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Announcements

Brad Hume announced that his conversation with Russ Zellers had resulted in the information that the Rollover funding from last year is finally in contract for the agency doing eviction prevention work. ALRP had been able to bring in several Housing interns.

Evaluation of Success of Committee in Prioritization

Pam Sims felt that the Committee's goals and objectives were clear to the Council. *Brad Hume* felt that the Rollover Funds would be well spent, covering repairs and maintenance as well as emergency assistance. *Amy Cunninghis* remarked that *BH* contribution and his leadership were exceptional. *Kevin Johnson* said he was inspired by the importance of the Committee's work.

Evaluation of the Failures of Committee in Prioritization

PS felt that sometimes the Committee is frustrated regarding the process and some level of disorganization on the part of the Council. *Catherine Geanuracos* felt that the prioritization process was confusing and needs further clarification. *Fernando Gomez-Benitez* found an excess of competing interests in the Council. *BH* believed that a kind of stigma operates with regard to recommendations from the Housing Committee. Others noted the lack of other working committees. It was felt that the consumer's voice is at times not clearly heard. Overall the Committee felt a degree of polarization in the Council.

Prioritization in General

BH reviewed the following items for future consideration:

Looking for other sources of funding.

The upcoming Needs Assessment, with the opportunity to focus on the questions asked about housing.

Prioritizing the housing needs with DPH. Giving clients choices.

Adjournment

Draft until approved by Council at next meeting

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I. Call to Order
4:30 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
Catherine Geanuracos added three items to the Agenda. A Membership Committee Vote, in addition to the Report. Two Steering Committee Report items were added; Planning Council Support Structure and Needs Assessment / Current Status. The revised Agenda was approved.

IV. Review and Approval of Minutes
07/30/01 and 08/13/01 Council Meeting Minutes – *Sam Kaplan* will provide minute corrections directly to staff. *SK* wanted to know why something was changed from a five-year plan to a three-year plan? By voice vote, the Council Meeting Minutes were approved. Several members abstained.

V. General Announcements
Laura from DPH handed out new EMA Reports to all Council Members and Public Requests. Thank you to all who contributed.

VI. Public Comment
There was no public comment.

VII. Reports

- **Membership Committee - VOTE**
Ken Pearce referred to the recommendations for Council Members filling Mandated seats. *Charlene Pugh* and *Christopher Schnyer* were recommended for consideration by the full Council. *Christopher Schnyer* introduced himself as the Planning Coordinator for San Francisco Community Clinic Consortium. *Charlene Pugh* introduced herself as the Clinic Manager for the UOP Dental School. See Attachment for further biography information. The Council members present approved these two new candidates unanimously. *John Conley* invited these new candidates to sit at the table.
CG brought up the question of holding seats. *KP* reported that three seats are currently being held for people who meet specific requirements. A discussion took place concerning where the Council is currently represented and what group needed more representation. No consensus of a solution was met.

- **Housing Committee**
Brad Hume reported that the Housing Committee reviewed their past successes, the problem of information transportation and *BH* urged all Council Members to attend the Housing Committee.

- **PWA Caucus**
Gary Harrell reported that the PWA Caucus subjects of discussion were co-chair elections, needs

assessment, and the spending of unfund money. *BH* reported that a committee member, *Eric Whitney,* has put together a proposal to provide a facilitator to assist the PWA Caucus with structure and leadership development, using the unfund money. This proposal is still being constructed. *BH* urged Council Members to attend the committee meeting.

- **Implementation & Evaluation Committee**
  Committee report undetected.

VIII. Break

- **Steering Committee**

Planning Council Support Structure

The Planning Council needs a new support structure, including a coordinator and an administrative assistant. The structure proposed was to increase the staff by one full time coordinator, one full time administrative assistant, and maintain the .8 time HIV Consumer Rights Advocate. Increase from 1.8 to 2.8. *Ken Bukowski, PRC*, presented the draft outline and job descriptions. Discussion around the status. duties. responsibilities and budget needs were discussed. A vote was scheduled for the next Council Meeting, with some discovering work to take place.

Co-Chair Elections - VOTE

Gary Harrell asked the Council for a point of clarity. His question was 'Does someone need to be a Council Member to hold a position, i.e. Co-Chair on a Committee?'. The answer is no. *CG* and *Jim Mitulski* introduced the candidates for Council Co-Chair, explained many responsibilities of Co-Chairs. The point was stressed that groups that needed representation included women, PLWH and people of color. Ballots were handed out. *CG* reminded everyone that they need to sign their ballots and may write in anyone other than those noted. Candidates were nominated and seconded. All candidates made a brief statement and questions were posed to some candidates. The three Co-Chairs elected are *Catherine Geanuracos, Donald Frazier* and *Jim Mitulski.*

Committee Structure/New or Ad-hoc Committees

There is an immediate need for Council members to attend Committee meetings. The attendance requirement is five meetings a quarter. The Council is also looking for ideas for new committees, and ideas about the structure.

Clarify Meeting Schedule

This issue was not addressed.

Needs Assessment / Current Status

A request for proposals was put out. A Current Status report was handed out and the next Needs Assessment was scheduled for November 13, 2001, 4:30 – 6:00 PM. .

IX. New Business

X. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

October 22, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P	✓								
2. Toni Butler	*TB*	P	✓								
3. Jeff Byers	*JB*										
4. Bart Casimir	*BC*										
5. Cecilia Chung	*CC*	P	✓								
6. Raymond Combs	*RC*										
7. John Conley	*JC*	P	✓								
8. Larry Cruz	*LC*										
9. Dirk Doepfner	*DD*	P	✓								
10. Mark Dunlop	*MD*										
11. Donald Frazier	*DF*	P	✓								
12. David Gant	*DG*	P	✓								
13. Catherine Geanuracos	*CG*	P	✓								
14. Fernando Gomez-Benitez	*FGB*	P									
15. Elyse Graham	*EG*	P	✓								
16. Gary Harrell	*GH*	P	✓								
17. Brad Hume	*BH*	P	✓								
18. Anthony Huynh	*AH*	P	✓								
19. Kevin Johnson	*KJ*	P	✓								
20. Sam Kaplan	*SK*	P	✓								
21. Carmen Madriz	*CM*										
22. Allen Meyer	*AM*										
23. Jim Mitulski	*JM*	P	✓								
24. Edward Patterson	*EP*	P	✓								
25. Wayne Peace	*WP*										
26. Ken Pearce	*KP*	P	✓								
27. Alissa Riker	*AR*	P	✓								
28. M.Jay Sanders	*MJS*	P	✓								
29. Susan Shea	*SS*										
30. Janis Takamoto	*JT*	P	✓								
31. Bob Teague	*BT*										
32. Jose Villarce	*JV*										
33. Mary Jane Wood	*MJW*	P	✓								
34. Karen Wuopio	*KW*	P	✓								

HIV Health Services Planning Council

City Hall, Room 201 1 Dr. Carlton B. Goodlett Place

November 26, 2001 4:30 PM

AGENDA

I.	Call to order	4:30 PM
II.	Roll Call	
III.	Review and Approval of Agenda	
IV.	Review and Approval of Minutes	
V.	General Announcements	4:35 PM
VI.	Public Comment	4:40 PM
VII.	DPH Quarterly Report – Michelle Long Dixon	5:00 PM
VIII.	Committee Reports	
	• *Membership Committee* - VOTE	5:20 PM
	• *Housing Committee*	5:35 PM
	• *PWA Caucus Committee*	5:45 PM
	• *Needs Assessment Committee* - Update	5:55 PM
	• *I & E Committee* – Reductions Protocol	6:05 PM
IX.	Meal Break	6:15 PM
	• *Steering Committee*	6:30 PM
	- Planning Council Support Budget	
	- Update on Hiring Process	
	- Retreat Update – Dates, Issues to be Discus	
X.	New Business	7:10 PM
XI.	Adjourn	7:30 PM

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Upcoming schedule of dates/meetings (subject to change):

Day	Date	Type of meeting	Location	Time
		NO DECEMBER COUNCIL MEETING		
Wed	12/05	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	12/05	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Tues	12/18	Needs Assessment	25 Van Ness, Room 330	4:30 – 6:00 PM
Thurs	12/20	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Wed	01/02	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	01/02	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	01/07	Implementation & Evaluation Committee	25 Van Ness, Room 330	4:30 – 7:30 PM
Tues	01/15	Needs Assessment	25 Van Ness, Room 330	4:30 – 6:00 PM
Mon	01/28	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

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16. Gary Harrell	*GH*	P	✓								
17. Brad Hume	*BH*	P	✓								
18. Anthony Huynh	*AH*	P	✓								
19. Kevin Johnson	*KJ*	P	✓								
20. Sam Kaplan	*SK*	P	✓								
21. Carmen Madríz	*CM*										
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28. M.Jay Sanders	*MJS*	P	✓								
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30. Janis Takamoto	*JT*	P	✓								
31. Bob Teague	*BT*										
32. Jose Villarce	*JV*										
33. Mary Jane Wood	*MJW*	P	✓								
34. Karen Wuopio	*KW*	P	✓								

HOUSING COMMITTEE

Meeting Date: November 7, 2001

Meeting Place: 25 Van Ness Avenue, Room 330-A, 3:00-5:00 PM

Members Present: Brad Hume (Chair), Margot Antonetty, John Conley, and Kevin Johnson

Others Present: Amy Cunninghis (SF AIDS Foundation); Marc Trotz and Daisy Leyva (DPH-HUH); Rodney Murphy & George Simmons (Catholic Charities); Jeffrey Harding (minutes).

Next Meeting: Wednesday, December 5, 2001, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Announcements

Brad Hume announced that he would be seeking the Co-Chairmanship of the PWA Caucus and asked if any of the Housing Committee members would have any objection. No one stated opposition.

HIV Access Information Report

Margot Antonetty presented a report regarding the HIV Access Information reviewing the Emergency Housing Program, the Broderick Street Adult Residential Care Facility plans, and the Star and Camelot Hotels projected usage. *See Attached Report.*

Housing Waitlist (HWL) Information

Mark Trotz and *Daisy Leyva* presented an Information Sheet from the Department of Public Health, Housing and Urban Health. The information sheet gave background information of the HWL, ongoing activities list, and an explanation of Why the Client's Number on the HWL may Change. Packet included a list of programs, a Re-Certification form, Transfer form, and Authorization of Release of Information form. The HWL Open Enrollment for Youth and Families form was also provided and everyone was told to encourage clients to apply. All forms were provided in English and Spanish. *See Attached Information Sheet.*

Additional Announcements

Adjournment

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Housing and Urban Health
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Phone: (415) 554-2679
Fax: (415) 554-2658

MEMORANDUM

TO: HIV Health Services Planning Council – Housing Subcommittee

FROM: Margot d. Antonetty, Housing and Urban Health

DATE: November 7, 2001

RE: **UPDATE ON "RE-ENVISIONING AIDS EMERGENCY HOUSING"**

Last year, a large group of HIV/AIDS housing providers, Care Council members, consumers, and Department of Public Health (DPH) staff went through a planning process with the goal to "re-envision" the AIDS Emergency Voucher system. DPH Housing and Urban Health (HUH) has been working on implementing the suggestions; including writing RFPs, identifying funding sources and providers and developing the actual programs. that is replacing the Emergency Voucher system.

The Housing Subcommittee requested an update on the development and implementation of the new programs. For specific information, please refer to the HIV ACCESS INFORMATION sheet (updated 11/7/01); a roster with detailed information about each of the three different programs. Additionally, here are some updates and highlights:

Emergency Housing Program
Run by Tenderloin AIDS Resource Center (TARC), the Emergency Housing Program (EHP) started to accept clients on September 10, 2001 into the block of rooms that DPH master-leases at the Riviera Hotel. TARC coordinates the referrals and intakes and also provides on-site services to support clients in following through with their referring providers and their Care plans. TARC organizes a monthly meeting with the referring agencies, to assure that the new program is utilized to its fullest capacity. This includes, reevaluating allocations as well as policies. Within the next few weeks, we will add two rooms to the program that are located in an accessible hotel.

Medical Respite Beds at the Broderick Street Adult Residential Facility
The respite referral agencies were invited to the Broderick Street facility for an Orientation on the Medical Respite beds in September. While start-up took a few weeks longer than planned, the Broderick Street Adult Residential Facility is now licensed and has started to admit the first long-term clients this week. We are filling the facility slowly, occupying about four more of the 34 beds (24 long-term and 10 medical respite beds) per week. We are anticipating to accept referrals for the first respite beds the week of November 26th. A memo with detailed information will be send to the referral agencies this week.

Star and Camelot Hotels
Both of these sites are going through extensive rehab in order to update the buildings and make them accessible and appropriate for our population and for on-site service provision. The agencies collaborating on these projects have hired management staff and are working on development and implementation of the new programs. It is anticipated that the Star will open in January 2001. The Camelot will be opening in the spring of 2001.

For more information, please consult the HIV ACCESS INFORMATION sheet or call DPH Housing and Urban Health at 554-2679.

	Emergency Housing Program	Broderick Adult Residential Care Facility Medical Respite Beds	Star and Camelot Hotels
Site Description	20 rooms rented by DPH within two SRO hotels, the Riviera Hotel and the Kean Hotel.	Two-story licensed Residential Care Facility with 24 long-term beds in 12 rooms and 10 short-term respite beds in 5 rooms	Two SRO hotels currently undergoing major renovation. Star is in the Mission and has support services and community space and 50 rooms for long-term housing. Camelot is in the Tenderloin and has support services and community space and 55 rooms altogether. 44 of those rooms are for long-term housing and 11 rooms are for SFGH respite.
Provider/Coordinator	Tenderloin AIDS Resource Center (TARC)	Collaboration. Page Street Guest House w/Richmond Area Multi Services DPH - Housing and Urban Health Nurse Practitioner	Collaboration: Baker Places w/Tenderloin AIDS Resource Center (TARC), John Stewart Company (JSCO) and Lutheran Social Services (LSS)
Number of Units available for referral by HIV providers	20 units	6 medical respite beds ear-marked for PLWH	33 units (16 at the Star; 17 at the Camelot)
Length of Stay	Each client will be allowed a maximum of four (4) weeks stay per year. Each stay may be from a minimum of 1 week to a maximum of 4 weeks	Each client will be individually assessed. Maximum stay is 60 days	Long-term housing.
Eligibility	• HIV positive • Resident of San Francisco • Income is 30% of median or less • Currently/chronically or at risk of homelessness	• HIV positive • Resident of San Francisco • Currently/chronically homeless or at risk • Medical complications requiring respite • Need to continue case management and medical services with referring agency	• HIV positive • Resident of San Francisco • Income is 30% of median or less • Currently/chronically homeless or at risk; incl. past utilizers of AIDS Emergency Housing • Participation in 3rd party rent payment
Access Points	1. Mission Neighborhood Health Center 2. Glide Goodlett HIV Services 3. Tenderloin AIDS Resource Center 4. Black Coalition on AIDS 5. Positive Health Program – Ward 86 6. Catholic Charities 7. Forensic AIDS Project 8. Castro Mission Health Center 9. Tom Waddell Health Clinic 10. Asian Pacific Islander Wellness Center* 11. St. Mary's HIV Services* 12. Haight Ashbury Free Clinics* 13. Lyon Martin Women's Health Services* 14. Native American Health Center* 15. TLC Program at Continuum* 16. San Francisco AIDS Foundation * = *Integrated Services Agency*	1. Mission Neighborhood Health Center 2. Forensic AIDS Project 3. Positive Health Program – Ward 86 4. Castro Mission Health Center 5. Tom Waddell Health Clinic 6. St. Mary's HIV Services* 7. Haight Ashbury Free Clinics* 8. Lyon Martin Women's Health Services* 9. Native American Health Center* 10. TLC Program at Continuum* 11. Asian Pacific Islander Wellness Center* 12. Glide Goodlett HIV Services	1. Mission Neighborhood Health Center 2. Glide Goodlett HIV Services 3. Tenderloin AIDS Resource Center 4. Black Coalition on AIDS 5. Positive Health Program – Ward 86 6. Catholic Charities 7. Forensic AIDS Project 8. Castro Mission Health Center 9. Tom Waddell Health Clinic 10. Asian Pacific Islander Wellness Center* 11. St. Mary's HIV Services* 12. Haight Ashbury Free Clinics* 13. Lyon Martin Women's Health Services* 14. Native American Health Center* 15. TLC Program at Continuum* 16. San Francisco AIDS Foundation 17. Baker Places, Inc.

HIV ACCESS INFORMATION

DRAFT

	Block of 20 Rooms	Broderick Residential Care Facility HIV Respite Beds	Star and Camelot Hotels HIV Units
Allocation	Proposal: Each agency receives a specific number of emergency housing weeks each year, according to the percentage allocation of the *"old emergency voucher system"*. Regular meetings with providers will be held to ensure that beds are utilized and to make any necessary adjustments to allocations or relevant policies.	Proposal: The six beds earmarked for PLWH are to be filled by the designated medical access points. There are no allocations per agency. The Broderick Street Nurse Manager has full discretion to make decision about intake; when necessary s/he will consult with the Broderick Street Administrator and/or the Medical Director of Housing and Urban Health. The beds have to be filled according to the Respite policies and procedures.	Proposal: Each of the first 16 access points will be allocated two of units; Baker Places will be allocated one unit. The units have to be filled according to DAH policies and procedures.
Start-Up/Rent-Up	9/01	11/01 on	1/02 on

City and County of San Francisco
Department of Public Health

Housing and Urban Health
101 Grove Street, Room 119
San Francisco, California 94102-4505

HOUSING WAITLIST (HWL) INFORMATION SHEET

BACKGROUND

On July 1, 2001, the Department of Public Health's Housing and Urban Health Section assumed management of the Housing Waitlist (HWL) from the San Francisco AIDS Foundation. At that time, HWL data was transferred to DPH through the Reggie system. The transfer of responsibilities to the DPH did not affect the ordering of clients' numbers on the housing waitlist.

ON-GOING ACTIVITIES

Open Enrollment: The Department of Public Health is accepting applications for the Housing Waitlist (HWL) from **November 5 through November 23, 2001**. The open enrollment is for youth and families. New clients added on the list will not affect the numbers of clients already registered on the waiting list.

Monthly Meetings: A meeting is held with all HWL housing providers every third Friday of the month at Room 302, DPH, 101 Grove Street. This meeting may be attended by any interested party.

Re-certification: The HWL staff re-certify or update client information as clients go up on the list. The HWL Office has been sending update letters to clients who have not submitted their letter of diagnosis to HWL or to Reggie.

Mail out of Section 8 announcement: The HWL Office mailed out the announcement of the Section 8 opening to all clients on the HWL in September.

Reggie: The HWL Office is now a Reggie site. HWL staff are able to look up additional client information in the Reggie system.

Staffing: The new HWL Coordinator will be starting on November 19, 2001. The new person is bilingual in Spanish and English.

WHY A CLIENT'S NUMBER ON THE HWL LIST MAY CHANGE

A client's number on the housing waitlist is determined by his/her brief enrollment date (BE Date). The earlier the client enrolled, the higher that client's place is on the list. That BE date is a "locked" field in the HWL database and once put in cannot be changed by HWL staff. However, a client's number on the list may change due to the following reasons:

1. Formerly inactive clients have been made active. For example, a client who moves to another State may request that he/she be inactivated or the HWL may inactivate a client who cannot be located. A client who is inactive, may activate his/her HWL status ANYTIME by calling the HWL Office.
2. Clients who have been referred to housing programs were not placed and were put back on the list. Clients who are referred to a program are temporarily taken out of the list. When this is done, a client's number will go up on the list because the people in front of him/her are gone. However, if the referral is not successful, the clients who were referred are put back on the list resulting to another adjustment in housing wait list numbers.
3. Clients have been previously provided a "housing program specific" number by the SF AIDS Foundation. For example, a client may be number 20 in the HOPWA program or number 10 in the SFAF Partial Subsidy program. The number that the DPH provides to clients, in most cases, is their number in two major service categories comprising of a total of 18 programs. In other words, numbering for the 18 programs have been merged resulting in a change in clients numbers. While on the surface this might look like a longer wait, this system benefits clients greatly because as long as they qualify for a program, they have a chance of being called when their name is on top of the list regardless of whether they signed on to the specific housing program or not.
4. Clients may be confused between their comprehensive intake number and their number on the list. The comprehensive intake number is the number provided by the SF AIDS Foundation to the client in order of when they will be asked to come in to complete their intake. The DPH HWL number is the client's ACTUAL number on the waitlist based on the Brief Enrollment Date.

IMPORTANT NUMBERS

HWL Number: (415) 554-2690 HWL Fax: (415) 554-2620

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PWA CAUCUS MEETING

Meeting Date:	November 7, 2001
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:30 PM
Members Present:	Cecilia Chung (Co-Chair), Gary Harrell (Co-Chair), Dirk Doepfner, Brad Hume, Kevin Johnson, Edward Patterson, Wayne Peace, Ken Pearce, MJay Sanders
Others Present:	Richard Bargetto (HIV Consumer Rights Advocate); Joseph Cecere (DPH), Felicia Elizondo and Charles Siron (Appointees to Council); Marc Trotz and Daisy Leyva (DPH-HUH); Ed Bedard, John Claude Koury, Eric Whitney and Hank Wilson, (Consumers); and Jeffrey Harding (Minutes)
Next Meeting:	Wednesday, December 5, 2001, 25 Van Ness, Room 330-B, 5:30-7:30 PM

I. Introductions

Persons in attendance introduced themselves.

II. Agenda

Announcements, HWL Update, Consumer Rights Advocate, Co-Chair Elections, Meeting time/day, New Business. Agenda was approved.

III. Housing Wait List Information Sheet / Update

Marc Trotz and *Daisy Leyva* presented an Information Sheet from the Department of Public Health, Housing and Urban Health. The information sheet gave background information of the HWL, ongoing activities list, and an explanation of Why the Client's Number on the HWL may Change. Packet included a list of programs, a Re-Certification form, Transfer form, and Authorization of Release of Information form. The HWL Open Enrollment for Youth and Families form was also provided. Everyone was asked to encourage anyone eligible to apply. All forms were provided in English and Spanish. Questions and comments followed. *Hank Wilson* asked the definition of 'youth'. Youth is 18-24 years of age, resident of San Francisco, and diagnosed with HIV/AIDS. *Eric Whitney* asked the definition of 'family'. Family is a couple, a person with an attendant, partners with no requirement of legal proof of marriage, or any partnership. Income verification is necessary for referral. *EW* made the point that someone currently on the list whose circumstances may have changed and is now eligible for 'family' services did not receive this notice. *Daisy Leyva* stated that the re-certification form was sent out with a question about number of persons in your family. This re-certification form is confusing to applicants and the HWL Staff said that they would make an effort to clarify and educate the HWL participants with additional outreach. *MT* reiterated that it is the client's responsibility to notify HWL staff of any changes in status. *MT* stated that the main task of the HWL is placement. *See Attached Information Sheet.*

IV. Consumer Rights Advocacy Project Report

Richard Bargetto reviewed the new cases for the months of September and October 2001. There were two grievances against the Housing Wait List (HWL). Clients did not understand their positions on the list. After contacting the HWL staff, clients seemed more satisfied with the explanation and will follow up if necessary at the PWA Caucus meeting with DPH-HUH representatives in attendance. One grievance against AHP is still unresolved and awaiting response from provider. Advocacy Project is monitoring one grievance against Derek Silva Case Management. There were 16 referral calls. *See Attachment A*

V. Co-Chair Elections

Two Co-Chairs were elected from the meeting with all present Council members voting. *Brad Hume* and *MJay Sanders* were elected new PWA Caucus co-chairs.

VI. New Business / Next Agenda

Kevin Johnson said he is meeting with African American organizations to discuss consumer attendance at the Caucus and the opportunity to recruit underrepresented individuals to apply for membership to the Council.
Eric Whitney gave a short report on the Coordinated Statement of Need prioritization process that has been completed recently from the Statewide Consumer Advisory Committee.

VII. Adjournment

HIV CONSUMER RIGHTS ADVOCACY PROJECT
1540 Market Street, Suite 301
San Francisco, CA 94102
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PWA CAUCUS – OCTOBER 2001 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Case Mngt	Positive Resource Center	Alleged Professional Negligence	Resolved
2-	Housing	DPH/HWL	Confusion with HWL	Pending
3-	Legal	ALRP	Quality of Services	Resolved
4-	Primary Med	St Mary's	Quality of Services	Resolved
5-	Mental Health	AHP	Reggie	Pending
6-	Housing	HWL	Management of List	Pending
7-	Food	Open Hand	Re-instituting services	Pending
8-	Case Management	SFAF	Quality of services	Resolved
9-	Case Management	SFAF	Quality of services	Resolved
10-	Case Management	SFAF	Quality of services	Resolved
11-	Case Management	Derek Silva	Unauthorized Services	Resolved
12-	Legal	ALRP	No services	Resolved

1- Client claims that he received incorrect advice from a benefits counselor. As a result of this alleged incorrect information, client claims that he did not have insurance coverage during a month when he incurred services. Now the client has a medical insurance bill for $1,200. Client filed a grievance with PRC claiming professional negligence. After an investigation, PRC responded that the benefits counselor does not recall the events as the client had stated. PRC agreed to include the critical information in the next in-service training and offered to assist the client to pay off his medical bills with a payment plan. Client is dissatisfied with the response and has appealed to members of the Board of Directors who have drafted a letter to the client's former employer. This employer just filed bankruptcy this month. Although the client appreciates the efforts of PRC's Board Members, client is dissatisfied with the resolution of the case because he medical bills were never paid.

2- Client claims he signed up with the Housing WaitList (Chips) in 1992 and then moved into Derek Silva in 1994. In 1994, while in a deteriorated condition, he claims that he received a phone call for a housing subsidy. Because of his condition, he declined the subsidy. Now, client would like the subsidy based on the theory that his residency at Derek Silva was temporary and he is now in a condition to accept his subsidy that was offered to him many years ago. Advocacy Project has contacted HWL, SFAF, Shanti and Derek Silva and has reviewed documents in order to determine whether client was aware of his long-term placement at Derek Silva. Client and Advocate will also meet HWL Program Manager for a meeting to discuss the issues.

3- Client had recent bad experiences with the ALRP in regards to ineffective advocacy, unprofessiona conduct. With the assistance of the Advocacy Project, Client filed a grievance with six specific allegations about the poor services he received. The ALRP responded and the client is not satisf with a majority of the response. With the assistance of the Advocacy Project, client appealed the decision to the Board of Directors who responded that an investigation was conducted and the ALF acted appropriately about the allegations of poor services. The client is dissatisfied with the final response.

4- Client claims the services at St. Mary's have greatly deteriorated over the past five years. Specifically, client had to wait for services, high turnover of staff, etc. Also, after client was referr to the Pain Clinic, he allegedly threatened the provider and was discharged from the program. Additionally, because of his dismissal from the pain clinic, he was also dismissed from the Health Center at St. Mary's. Advocacy Project has contacted St. Mary's to determine the circumstances around the dismissal and assisted client in locating new health care. Advocacy Project spoke with te Clinical Coordinator who said that no re-admission to the clinic would be possible for this client because the doctor believed the threats to be real. Client was referred to the Medical Board of California grievance office. Client is dissatisfied with the resolution.

5- Client sought services from AHP. During his intake client was informed that the information woul be shared with two other agencies, Shanti and SFAF. Client did not want his personal information shared, thus, the intake process concluded because AHP could not proceed with the intake without disclosing the information to the other two agencies. Clients contacted the Advocacy Project who has assisted the client in filing a grievance on how clients can access mental health services from AHP with have the information shared with the other two agencies in the HIV Services Partnersh AHP responded with a special mechanism for this particular client to access services without hav his information shared. Client wants this service for all clients and Advocacy Project is assisting th client in requesting AHP to offer this service to all clients.

6- Client is concerned about how the HWL is being managed. Specifically, why a letter of diagnosis is necessary by the DPH when the reggie system could provide this information. The client's second concern is the list's request for income verification which can vary widely in one year for a client depending on their health status. The Advocacy Project has contacted the HWL and inquired into these questions on behalf of the client. The HWL's response was that the HIV information was not always provided for even if the client was registered in the reggie system. Additionally, the income information was static and could overlook a person for a program if he/she was otherwise eligible. However, this income information could be changed at anytime by the client calling the HWL to updating their records. Client is not satisfied and is considering an appeal.

7- Client was forbidden to enter the premises on Project Open Hand for three years due to his hostile and abusive conduct and was denied services from the collaboration for one year. Now that year is complete and the suspension of services from the HIV Services Partnership has been removed, clien would like to begin receiving groceries from Open Hand. Advocacy Project has contacted Project Open Hand and requested a surrogate shopper for the client so that Project Open Hand's safety need are carefully balanced with the client's need for food. Advocacy Project is assisting client in documenting his good faith effort to minimize future incidents by enrolling in anger management classes. Project Open Hand is preparing a letter for limited reinstatement of services.

8- Client claims that when he and his partner were in Los Angeles they called the SFAF for assistance. When they arrived at the SFAF the client claims he was not treated with compassion. When he did receive a hotel voucher to the New Pacific Hotel he encountered prostitution & johns, bloody syringes in the bathrooms and their door was kicked in by another guest. When he returned to the SFAF and complained about the health risks at this hotel, they were then given an voucher to the Elm Hotel which they believe was not an improvement and contained urination & defacation in elevator and unclean and damaged room. Client has stopped taking his medication to protest the conditions of these hotels. Advocacy Project referred to AEF to find another hotel. Client is satisfied with this temporary measure.

9- Client claims that he has been positive for seven years and has some documentation which tends to suggest that he is HIV positive and went to the SFAF seeking services. The SFAF denied services until results from a local testing center could be established or an out-of-state verification could be confirmed. The client's own records seem to indicate that the client is positive from collateral documentation (copies of prescriptions, tuberculosis forms, diagnosis form from APLA); however the results from a test at the Health Center #1 stated that he was HIV negative. Advocacy Project has contacted APLA and client's doctor in Florida to request further documentation as well as referred client to an additional local clinic for re-testing. The documentation provided by the Florida doctor is inconclusive. The grievance has been withdrawn through inaction.

10- Client went to the SFAF seeking services for counseling on going back to work and disability. Client claims that he was treated poorly by staff for merely being "edgy and nervous" which he claims was not allowable conduct. With the help of the Advocacy Project, client wrote a grievance about his experiences and the SFAF responded. The client is not satisfied but does not wish to pursue the grievance process.

11- Client claims that a case manager at Derek Silva distributed to his partner his psych meds. The client claims that case manager and the resident agreed these meds would be safer if placed in the case manager's office. The client claims that once a week, the resident would have to ask the case manager for his meds and they would eventually be given out by her. Advocacy Project has assisted the client in filing a grievance asking that a policy be put in place so that case managers are not distributing medications. Advocacy Project is monitoring the grievance. Client received a response to which the client disagrees; however, because he agrees that he does not have enough information to refute her denials, the client will not proceed. Client is dissatisfied with the outcome.

12- Client contacted the ALRP for many issues regarding his housing. Client claims that because of their inaction, the landlord has notified HOPWA about some of the client's violations. Client claims that if ALRP had been involved, he would not be threatened with losing his HOPWA certificate. Advocacy Project has contacted ALRP to investigate the facts and determined that the ALRP had in fact referred client to a referral attorney thereby providing services to client. Because client was not satisfied with the outside referral attorney, client was dissatisfied with the outcome.

NEW CASES

	Service	Agency	Issue	Outc
1-	Housing	HWL	Alleged Misplacement	Pending
2-	Housing	HWL	Alleged Misplacement	Resolve
3-	Mental Health	AHP	Denial of Services	Pending
4-	Case Management	Derek Silva	Breach of Confidentiality	Pending

1- Client claims that only a few months ago his subsidy placement on the HWL was about 300. Now client claims that since the HWL has been transferred to the Dept. of Public Health his number has dropped to about 800. Although the client understands that some movement on the list is likely, he believes that a 500 drop in placement is outside the scope of a normal fluctuation. Client and Advocate will meet with staff from HWL at the next PWA Caucus meeting.

2- Client claims that he signed up for the HWL/Chips in December 1996 and cannot understand why h has not received his subsidy. Advocacy Project contacted the HWL to determine the client's "real" placement number which was 384 for the subsidy program. Client was also advised to investigate other housing options to avoid homelessness rather than simply wait for his subsidy which would probably not arrive for about one year. Advocacy Project also assisted client with seeking new case management. Client is satisfied with his current position on the list and with the resolution.

3- Client claims that he went to AHP to receive services. While waiting for his appointment, he stepp outside to have a cigarette. Client is an advocate for the use of medical marijuana and on that da was wearing a hat and t-shirt which demonstrated his perspective on the issue. When the time of h appointment arrived, the client was denied services because the staff at AHP believed the client had smoke marijuana outside before his appointment. Client also claims that when he asked to file a grievance he was told that no grievance procedure was available to him. The Advocacy Project assisted the client in filing a grievance and is awaiting a response from AHP.

4- Client claims that his case manager at Derek Silva disclosed his drug use to client's father without h consent. Client denies any drug use and has filed a grievance against the case manager for improper conduct. Advocacy Project is monitoring the grievance.

Referral Calls:	Italian AIDS Organization	1
	Derek Silva Grievance Procedures	2
	AHP Services	2
	ALRP Services	4
	Other Legal (Bar Assoc & Immig Project)	2
	HWL Services	1
	Case Management Services	1
	Peter Claver Grievance Procedures	1
	Open Hand Grievance Procedures	1
	Miscellaneous	1
	Total	16

* Duplicated Client

(Report prepared by Richard Bargetto on 10/31/01)

NEEDS ASSESSMENT MEETING

Meeting Date:	November 13, 2001
Meeting Place:	25 Van Ness Ave., Room 330-A
Meeting Time:	4:30 to 6:00 PM
Members Present:	Donald Frazier (Co-Chair), John Conley, Catherine Geanuracos, Sam Kaplan, Ken Pearce, MJay Sanders
Others Present:	Joseph Cecere (DPH); Ken Bukowski (PRC); and Jeffrey Harding (Minutes)
Next Meeting:	Tuesday, December 18, 2001, 25 Van Ness, Room 330-B, 4:30-6:00 PM

I. Agenda

This meeting is to review the request submitted by the sub-contractor for a Request for Proposals.

II. Needs Assessment Request for Proposals

Ken Bukowski handed out the request sheet to all for review and suggestions. Main concerns of the members included the methodology of information gathered, the strategy to collect samples, the cultural competency of the surveyors, the page limit proposed, and the EMA definition as well as HRSA requirements.

III. New Business / Next Steps

KB will take all suggestions made at the meeting, incorporate them into the RFP, and drafts will be exchanged by committee members via e-mail. All RFP's are due by December 17, 2001, noon.

III. Next Meeting

The next meeting of the Needs Assessment Committee will be Tuesday, December 18, 2001, 25 Van Ness, Room 330-B, 4:30-6:00 PM

VI. Adjournment

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HIV Health Services Planning Council Needs Assessment

Background

One of the primary duties of the Planning Council is to determine the needs of the population of individuals with HIV disease within the EMA with particular attention to: (1) individuals with HIV disease who know their HIV status and are not receiving HIV-related services and (2) disparities in access and services among affected subpopulations and historically underserved communities.

The purpose of the needs assessment is to help the Planning Council understand the characteristics and trends of the local HIV epidemic, identify service needs and assess the resources that are currently available to meet those needs. In previous years, the Council's needs assessments have primarily targeted persons living with HIV disease who were receiving HIV-related services. The reauthorization language for the Ryan White CARE Act now requires the Planning Council to develop or expand the needs assessment process so as to determine the needs of those individuals who know their HIV status and are not in care. The needs assessment must address disparities in access and services of underserved populations and affected subpopulations. The needs assessment must also identify any capacity development needs. Capacity development needs result when disparities in the availability of HIV-related services are identified, particularly in historically underserved communities.

The needs assessment must be completed by April 2002 so that the results can be incorporated into the Council's priority setting, allocation of resources and capacity development activities for 2003.

Scope of Work

The Planning Council seeks a subcontractor to assess the needs of people living with HIV disease within the EMA as noted above. Specifically, consulting services are sought to:

1. Conduct a comprehensive assessment of unmet service needs for the EMA with a primary focus on individuals who know their HIV status and are not in care.

2. Conduct an assessment of the current service system's capacity and resources. This assessment should include an examination of the utilization of services and of the disparities or gaps in the availability of HIV-related services, particularly for historically underserved populations.

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Membership Committee November Report

Meeting Date: November 15, 2001

Meeting Place: 25 Van Ness Ave., Room 330-A, 5:30 – 7:00 PM

Meeting Time: 5:30 to 7:00 PM

Members Present: Felicia A. Elizondo, David Gant, Anthony Huynh, Edward Patterson, Ken Pearce (Chair), MJay Sanders, Jose Villarce

Others Present: Norman Tanner (Nominee to Council) and Jeffrey Harding (Minutes)

Next Meeting: Thursday, December 20, 2000, 25 Van Ness, Room 330A, 5:30-7:00 PM
Meetings will generally be held on the 3rd Thursday of each month.

Statistical Breakdown of Current Membership

KP presented the overall profile with several charts and percentages. He indicated that he would attempt to highlight where there was the greatest need. The charts and percentages are constantly changing. The most crucial area of recruitment is with African American HIV+ people. The unaffiliated consumers are low as well, and their ethnic breakdown is not balanced. Most are white, and few are people of color. Gender is also unbalanced for the unaffiliated consumers.

New Member Interviews

Norman Tanner was interviewed by committee members and answered several questions about his desire to be a Council members and his qualifications.

New Member Recommendations

KP had a motion to recommend *Norman Tanner* and *William Blum* for membership to the Council at their next meeting. This was agreed to unanimously.

Reappointments

Ken Pearce had a motion to recommend current member, *Catherine G. Geanuracos*, to Council at their next meeting. This was agreed to unanimously.

Member Resignations

Raymond Combs has submitted his official resignation to the Council.
As of November 12, 2001, *Janis Takamoto* has submitted her official resignation to the Council.

New Member Orientation

A new member orientation is currently being planned for January 2002. The Membership is recommending that the new Coordinator meet with Membership Committee for orientation.

Election for New Committee Co-Chairs

KP opened the floor for nominations to committee co-chairs, but there were no nominations. The committee agreed to solicit candidates for the Membership Committee co-chairs at the next Council meeting.

Membership Committee Information

The Membership Committee is recommending the following member for reappointment to the Council:

- **Catherine G. Geanuracos**: She is a 31-year-old white, bisexual, HIV-negative female. She is the Director of Research and Evaluation at Larkin Street Youth Services. Larkin Street Youth Services is a Title I contractor and a Title IV grantee. She has extensive experience in Clinical Case Management to HIV+ youth, managed HIV housing and programs for homeless youth in addition to 7 years of HIV testing and prevention education. She has also managed data collection and reporting for multiple HIV Service contracts. She has been a member of the HIV Health Services Planning Council for two years and she currently holds the position of Co-Chair. Her category of representation includes Social Service providers, Housing and Homeless Service providers and Title IV grantees.

The Membership Committee is recommending the following new nominees for membership to the Council:

- **William Blum**: He is a 36 year old, white, gay, HIV-positive male. He is a past Consumer of CARE-funded services. He is the Client Services Coordinator, MSW, of the San Mateo County AIDS Program. In this position, he supervises social workers, a Health Outreach Team, benefits counselors, drug and alcohol councilors, and a health educator. He has been working in HIV Services for 12 years both in prevention and direct services in NYC; San Juan, Puerto Rico and San Mateo. While in NY he worked at the Hetrick-Martin Institute with GLBT street youth and at St. Vincent's Hospital AIDS Unit. While in San Juan, PR he worked with the Puerto Rico AIDS Foundation's Stop AIDS program and co-founded the HIV prevention organization, Coai, Inc, where he later served as Board President. He served on the San Juan Ryan White Title II Planning Council prioritizing community and service delivery needs, evaluated proposals and monitored contracts. Since 1995, he has worked for SMCAP. He has extensive experience on review panels evaluating program services with SMCAP and SFDPH. He has also served on the Community Advisory Board for CAPS "Bay Men Study". His category of representation includes almost every category listed on the nomination form.

- **Norman Tanner**: He is a 43 year old African American, bisexual, HIV-positive male. He is a Consumer of HIV-related services. He has worked with many HIV/AIDS service providers including GLBT Cultural Center Planning Committee, Narcotics Anonymous Relocation Committee, Haight Ashbury Free Clinic OPT Board, Black Brothers Self Esteem Leadership Institution, Northern California Service League Consultant and Leland House Crisis Intervention. He is currently the HAFCI Residential Manager for the HAFC & BVHPF AIDS Services, but will be resigning December 31, 2001. His category of representation includes almost every category listed on the nomination form.

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Minutes, November 26, 2001 **HIV HEALTH SERVICES PLANNING COUNCIL**

Draft until approved by Council at next meeting

I. Call to Order
4:30 PM

II. Roll Call
See Attachment A. A quorum was established.

III. Review and Approval of Agenda
The Agenda was approved.

IV. Review and Approval of Minutes
After numerous corrections were noted to the October Meeting Minutes, which were inserted into the permanent records, the minutes were approved by majority vote. A discussion took place regarding the By-Laws

V. General Announcements
Dirk Doepfner stated that he had just attended the First Step meeting of the Administrative Simplification of the Title I and Title II of the Ryan White CARE Act. One discussion topic was about moving to a bi-annual application. In addition, there was a question about how severe need is demonstrated and calculated. A report is due in the next month.
John Conley announced that San Mateo County was looking for a monitoring team to view Title I recipients. Please call him directly to participate.

VI. Public Comment
Several members of the public introduced themselves, they were there to view the meeting and interested in Membership.

VII. DPH Quarterly Report – Michelle Long Dixon *See Attached Report*

VIII. Reports

- **Membership Committee - VOTE**
  Ken Pearce reviewed current Council resignations. The Membership Committee is recommending *Catherine Geanuracos*, a 31-year-old white female, for reappointment to the Council. She is the Director of Research and Evaluation at Larkin Street Youth Services. The Membership Committee is recommending the following new nominees for membership to the Council: *William Blum*, a 36 year old, white male. He is a past Consumer of CARE-funded services. He is the Client Services Coordinator, MSW, of the San Mateo County AIDS and *Norman Tanner*, a 43-year-old African American male. He is a Consumer of HIV-related services. The Council unanimously approved these three candidates. *KP* reported that there is still no new Co-Chair for the Membership Committee.

- **Housing Committee**
  Brad Hume reviewed the Emergency Housing document, explained the Housing Wait List information sheet and answered questions. Co-Chair elections at the next Housing meeting.

- **PWA Caucus Committee**
  MJay Sanders reported that the Rollover funds were approved and needed. The Caucus meeting date may change to allow more attendance that is convenient.

- **Needs Assessment Committee - Update**
  Donald Frazier reported that the RFP was being worked on into a final document so the process could begin. *CG* stated that the RFP was sent out by PRC and proposals will be reviewed on December 18, 2001.

- **Implementation & Evaluation Committee – Reduction Protocol**
  This subject considered at the next Steering Committee meeting on December 10, 2001. *MLD* briefly explained the Reductions Protocol process.

IX. Break

- **Steering Committee**

Planning Council Support Structure - VOTE
The Planning Council Support funding was approved by a majority vote.

Update in Hiring Process
The solicitations have been made for the Planning Council Support and will be filled by the end of December.

Retreat Update – Date, Issues to be Discussed
Jim Mitulski volunteered to put out a survey to determine what date would be most convenient for Council Members and a facilitator to attend. *Wayne Peace* volunteered to collect a list of possible issues to be discussed at the retreat. This will be discussed at the next Steering Committee meeting on December 10, 2001

X. New Business

XI. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

	November 26, 2001		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1.	Margot Antonetty	*MA*	P	Y	Y							
2.	Toni Butler	*TB*	A									
3.	Jeff Byers	*JB*	P	Y	B							
4.	Bart Casimir	*BC*	A									
5.	Cecilia Chung	*CC*	P	Y	Y							
6.	John Conley	*JC*	P	Y	N							
7.	Larry Cruz	*LC*	P	Y	B							
8.	Dirk Doepfner	*DD*	A									
9.	Mark Dunlop	*MD*	P	Y	N							
10.	Felicia Elizondo (CN)	*FE*	P									
11.	Donald Frazier	*DF*	P	Y	Y							
12.	David Gant	*DG*	P	Y	Y							
13.	Catherine Geanuracos	*CG*	P	Y	Y							
14.	Fernando Gomez-Benitez	*FGB*	A									
15.	Elyse Graham	*EG*	A									
16.	Gary Harrell	*GH*	A									
17.	Brad Hume	*BH*	P	B	N							
18.	Anthony Huynh	*AH*	P	Y	Y							
19.	Kevin Johnson	*KJ*	P	Y	Y							
20.	Sam Kaplan	*SK*	P	Y	N							
21.	Carmen Madríz	*CM*	P	Y	Y							
22.	Allen Meyer	*AM*	A									
23.	Jim Mitulski	*JM*	P	Y	Y							
24.	Tracy Neil	*TN*	A									
25.	Edward Patterson	*EP*	P	Y	Y							
26.	Wayne Peace	*WP*	P	Y	Y							
27.	Ken Pearce	*KP*	P	Y	Y							
28.	Charlene Pugh (CN)	*CP*	P									
29.	Alissa Riker	*AR*	P	Y	Y							
30.	M.Jay Sanders	*MJS*	P	Y	B							
31.	Christopher Schnyer (CN)	*CSc*	A									
32.	Susan Shea	*SS*	A									
33.	Charles Siron (CN)	*CS*	A									
34.	Jose Villarce	*JV*	A									
35.	Mary Jane Wood	*MJW*	P	Y	B							
36.	Karen Wuopio	*KW*	P	Y	Y							

Note: CN = Council Nominee (No Voting Privileges)

2. Membership
3. Planning Council Support Budget

- **Results of CBC solicitation**

A solicitation for applications to provide services under the Congressional Black Caucus/Minority AIDS Initiative went out on July 7, 2001. Services solicited were: A) Client Advocacy/Treatment Adherence Services ($220,622); and B) Client Service Enhancement and Capacity Building ($116,601). Four new service awards were made. Services to be provided under this initiative for the current year are as follows:

Service	Target Population	New or continuing	Annual Amount
Client Advocacy, Treatment Adherence	Latinos in San Mateo County	New	$83,331
Treatment/Peer Advocacy	African American & Latino Transgenders	Continuing	$89,345
Client Enhancement and Capacity Building	Asian Pacific Islanders in San Mateo County	New	$45,247
Transitional Case Management	Incarcerated Persons of Color	Continuing	$135,556
Client Advocacy, Treatment Adherence	Native Americans	New	$71,000
Treatment/Peer Advocacy	Native Americans	New	$48,300
Treatment/Peer Advocacy	Monolingual Latinos	Continuing	$46,874 ending 2/28/02
Treatment/Peer Advocacy	African American Women	Continuing	$39,062 ending 2/28/02

- **Office of Minority Health Grant:**

Through the intervention of the office of Congresswoman Nancy Pelosi, San Francisco received a 1-year grant for $1,105,000 from the Federal Office of Minority Health, for the provision of services to a target population of HIV+ women, youth, African American men, monolingual Latino and transgender persons.

This grant presents an opportunity to pilot methods of identifying persons who may or may not know that they are HIV+, may or may not be receiving optimal care, and support them in developing and maintaining an ongoing relationship with a primary care provider.

The goal of this program – to eliminate disparities and increase health outcomes for the target populations - is a complement to the goals of the CARE legislation. Measurable objectives include quantifying the numbers of women and persons of color who know their status but are not in care, ensuring that people know their status through counseling and testing, making people aware of the services that are available to them and how to access them, linking people into medical care, ensuring that people are not lost to follow-up, and collecting data to ensure that appropriate services were provided.

Service Provider	Target Population	Description of Service
Dolores Street Community Services	Mono and bilingual Latino men in shelters	HIV Peer Advocacy Program: outreach, education, referral
Mission Neighborhood Health Center	Latinos – in SROs/shelters, day laborers	Outreach; HIV Counseling, Testing & Referral; and Treatment Advocacy
UCSF Positive Health Practice (Men)	African American men	Men of Color Program - Outreach, Peer/Treatment Advocacy in collaboration with the Black Coalition on AIDS
UCSF Positive Health Practice (Women)	African American women	Women' s Specialty Clinic - Outreach, Peer/Treatment Advocacy
Castro/Mission Health Center	Queer and Questioning of color	Expanded Access and Coordination of Health Care at Dimensions Clinic
SFGH	Women of color, residents of the Mission district, and general HIV population of SFGH	Increased Efforts in Adherence, Prevention & Outreach to the HIV-Infected; Clinical Infrastructure

- **2000-01 Carryforward award**

The list of carryforward requests as approved by the Planning Council was approved by HRSA, with all funds to be expended by 2/28/02. HIV Health Services staff will review plans for implementation with the I & E Committee.

- **Calendar**

HIV Health Services will distribute an annual planning calendar next month primarily intended for contractors. It will include Planning Council full meeting and committee dates for the 12-month period of December 2001 through November 2002. A copy of the calendar will be sent to all Planning Council members.

- **Solicitation for vouchers**

A solicitation was issued on Friday, November 21, 2001 for applications to distribute vouchers. This solicitation is only intended for those agencies that have not previously applied to receive vouchers and would like to do so.